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HEALTH IN HANDCUFFS

JOHN A. KINGSBURY

The National Health Crisis—and What Can Be Done

A NEW MODERN AGE BOOK

The Book and the Author

JOHN A. Kingsbury has long been a prominent figure in the field of public health, and he is gifted, in addition, with the ability to present his knowledge most interestingly.

In the present volume he treats fundamental issues in the field of health, discusses the very controversial socialized and group medicine proposals, shows us what medical science can do for modern Americans if it is allowed to operate freely for the benefit of all, describes the program embodied by the Wagner Health Bill, and in general gives a complete picture of the nation's ills and health assets.

In a world beset with threats to every nation's security, the first requirement must be a healthy population, and this is equally true in times of peace if democracy is to offer continued advantages to the great majority of the people. Dr. Kingsbury does not hesitate to probe to the roots of our difficulties, and where surgical treatment of the body politic is necessary he recommends it forthrightly and offers convincing evidence to support his findings and his proposals.

This is a book which will step on a great many toes, including those of some physicians and of the large industries which derive their income from the manufacture or distribution of products which directly affect public health. It is equally true, however, that no one can question the author's sincerity, nor that anyone could disprove substantially his report on American health problems and possibilities.

JOHN A. KINGSBURY

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MODERN AGE BOOKS · NEW YORK

PUBLISHED BY MODERN AGE BOOKS, INC.

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PRINTED IN THE UNITED STATES OF AMERICA

TO

MY WIFE

FOREWORD

In a broad sense, this book is based on more than a decade of research by the best qualified experts in the nation. The factual studies upon which I have drawn are embodied in hundreds of volumes; they have cost millions of dollars to compile. It has been my privilege for over thirty years to be intimately associated with the public health movement which has culminated in this decade of intensive research into the health of the nation. I look back with great satisfaction at the part I have had in promoting and securing financial support for some of the most important of these studies. Indeed, several of the basic projects were conceived and initiated by the staff of the Milbank Memorial Fund during the years when I was executive officer of the Fund.

As I have reviewed the material of these studies in the preparation of this book, I have realized as never before how important for society has been the public health movement of the past three decades. This movement now has a glowing vitality and it has attained such proportions as to give cause for great hopefulness. The National Health Program, developed under the leadership and encouragement of President Roosevelt, is now receiving attention throughout the nation. The Program is embodied in Senator Wagner's Health Bill. Just prior to the adjournment of Congress, August 5, 1939, this proposed legislation received general endorsement in a preliminary report filed by a Senate Committee in charge of this Bill.

I realize as never before the vital part played in this movement, and in the recent researches upon which I have so freely drawn, by a host of pioneers—veritable "Heroes of Health"—and by a legion of young

social and medical scientists who are bringing the health program to fruition and who are destined to carry it on into the field of action.

As this movement has become large, important and complex, those who have made significant contributions and who have been outstanding leaders have become subordinate to the movement itself. I find it impossible to pay appropriate individual tributes, much as I should like to do so. Among those to whom I am most indebted, physicians and laymen, living and dead, I must mention William H. Welch and Sir Arthur Newsholme, Hermann M. Biggs and Homer Folks, Linsley R. Williams and C.-E. A. Winslow, Theobald Smith and Paul de Kruif, Edgar Sydenstricker and I. S. Falk; and last, but by no means least, Elizabeth Milbank Anderson who established and endowed the Milbank Memorial Fund, and her cousin, Albert G. Milbank, the President of its Board of Directors, for twenty-five years my friend, counselor and loyal supporter. To all these and to hundreds of others whose names are engraved in my memory, I express my gratitude for their inspiration, their counsel, and their loyal support during the years in which we have worked together. To them I would pay profound tribute for leadership and devoted service. It is doubtful whether without them the public health movement would be nearly as far advanced for another quarter of a century as it is today.

I trust that this book may serve a useful purpose as a non-technical presentation of the nation's health problem for those who seek information and understanding in an unfamiliar field.

J. A. K.

Lavorika
Shady, New York
August 18, 1939

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HEALTH IN HANDCUFFS

I

MEDICINE AT THE CROSSROADS

"The health of the people is a public concern; ill health is a major cause of suffering, economic loss, and dependency; good health is essential to the security and progress of the Nation."

THE health of our people is our greatest wealth, precious above all other possessions. For the family and the individual, as for the nation, health is an indispensable condition to "life, liberty and the pursuit of happiness." Without physical and mental health, freedom is limited and the pursuit of happiness is but the shadow of its own substance.

Statesmen have long given lip service to the proposition that safeguarding the health of the people is the paramount duty of the state —a proposition honored more in the breach than in the observance. Today there is a new outlook. The people of our country now demand practical steps to provide adequate health services; they are no longer content with mere lip service to general principles and with inadequate provision for medical service.

Physical health has always been a patent necessity. As conditions of living become more intricate and complex, the importance of mental health is beginning to be recognized. With the loss of stability and security in our society, the strain upon mental normality and mental health is added to the increased strain upon physical health. Man is but flesh and blood and nerves; he can take just so much. If he is to retain his sanity, if he is to conserve vitality, if he is to be capable of meeting his problems, his personal machine must

be guarded and preserved. This is so obviously the concern of society, as well as of himself, that serious attention must now be given to the public health.

There was a time, perhaps a hundred years ago, when education was the privilege of the few. Today, education is the birthright of every citizen of the United States. We accept in our society the responsibility, even if still imperfectly realized, of providing to everyone an opportunity for a basic education. This has become one of the cornerstones of our democracy. We are only beginning to realize now that health for everyone is the keystone of our democracy and our economic society.

There are still many who, when reminded of neglect and inadequacy in our health services, point with pride to our splendid average health conditions. Are they content that one man's health shall offset another man's illness? They glow with satisfaction that our death rate is lower than that of some other country. Have we not vastly greater potential resources and wealth, and should not our death rate be much lower? They take refuge in the fact that our death rate is lower than it used to be. Is it really any comfort if our death rate is still deplorably high? They are content with the present situation because our sickness rates are, on the average, low. Does that fact give comfort to those who are sick and incapacitated needlessly, and from preventable causes? They defend the present organization of medical service by citing the average high rate of professional attendance on those who are sick. Is that average rate of much help to those who are unattended in their time of need, to the mother whose baby dies from lack of adequate attention, to the man whose wife dies in childbirth from a preventable cause, to the families whose loved ones are cut off for lack of care?

The average level of health or the average cost of sickness has little meaning for those who now must meet personal catastrophes. To know that a stream is 4 feet deep on the average is of little help to those who drown in places where it is 10 feet deep.*

* Message of the President of the United States to Congress, January 23, 1939.

When anyone tries to propose methods of dealing with these problems through something better than chance, when anyone proposes that we should deal with obvious needs through well-considered programs, the cry of "socialism and communism—inciting to revolution" rings on the editorial page of our leading medical journal.

We pay too heavy a price—in loss of money, economic strength, vigor, intellectual force, social security, and human happiness—for needless sickness and disability. In every community, whether in the city or on the farm, in the North or in the South, pain and suffering and premature death cry shame to our civilization. We can afford good health for everyone; we cannot afford not to have it. A health program for our democracy is a challenge to our statesmanship.

Medicine in the United States is today at a turning point in its history. In three or four centuries it has made almost incredible advances; it has risen from its origins in magic and mystery to science and art. These advances have come from the work of men and women in many walks of life, as often by those who were not physicians as by physicians. The contributions to medicine of people like Pasteur, Röntgen, Ehrlich, Madame Curie, are so great that most of us forget they were not physicians. Anyone who has read the history of medicine knows that the great advances have often been made against the vigorous—and sometimes even the bitter—opposition of physicians in high places.

Medicine has always reflected the culture of the society in which it practices and which it serves. Society as a whole, as well as the professions, can take great pride in the achievements of medicine. For medicine should be viewed as a cultural possession. Each of us owes a great debt to the medical professions—physicians, dentists, nurses, public health officers—not only for the part they have played in the advances of medicine but also for their services as trustees of a valued body of knowledge.

Yet, if I correctly read the signs of the times, medicine is today at a crossroads. Citizens in all walks of life are critically examining

the place of medicine in our society. Granting the great accomplishments of the past, they are nevertheless asking about the present and about the future. In the same period during which medicine has made great advances, the public has learned about the enlarged possibilities for service. Health education has done its work, and people now want to share in the benefits of modern medicine. Many are asking a simple and direct question: Why are we not receiving these benefits in our own lives? They now go even further; they ask:

How can matters be arranged better so that we can share in these benefits?

This is the crux of a great problem receiving public attention today—the problem presented to the National Health Conference held in Washington in July, 1938, at the suggestion of President Roosevelt, which aroused the nation and led to the Wagner Health Bill now before Congress.

There are questions concerning the organization of service, and these are primarily for the medical professions—medicine, dentistry, nursing, hospital administration—to answer. There are questions concerning the method of paying for service, and these are for the public and the professions to answer together. There are questions of social philosophy, and these society must answer.

Society's stake in health and welfare cannot be emphasized too strongly. A few members of the professions are accustomed to speak as though they, and they alone, can dictate to society what it shall have, what it shall do, and what it shall pay. Such talk is not only arrant but arrogant nonsense. Physicians are themselves privileged persons because society gives them special privileges. Society, in its effort to protect the public welfare, decides, by regulating the license to practice, who may and who may not hold himself out as a qualified physician. This special group whom society creates may not dictate to society as though it were master when it is really servant.

The great advances in medicine have in turn brought great prob-

lems in medical practice. The declining birth rate emphasizes the importance of protecting the lives of mothers and infants. The aging of the population, the increasing proportion of older people, emphasizes the burden of chronic illness and the need for its prevention and cure. The growing complexity of society emphasizes the importance of mental hygiene, the guidance of those who are mentally subnormal and the care of those who are mentally abnormal. Modern medicine has made only a bare beginning in these fields and in many others.

Further, and of equal importance, the advance of modern medicine has brought great problems in the organization of medical services and in the methods of paying for medical care.

As medical knowledge has advanced, it has become far too complex to be within the understanding of any individual.

> Formerly [said Dr. Ray Lyman Wilbur] the physician could carry in his head the sum of his knowledge and in his saddle bags the instruments and drugs of his profession. Today the physician must become acquainted with a vast technical literature of science; he must acquire proficiency in a difficult and ever-changing art; he must lean heavily and intelligently upon the special skill of his colleagues; he must utilize wisely the resources of hospitals, clinics and laboratories.

Even when a community has adequate facilities and enough physicians, how many are there who have not had to face the problem of how to choose a doctor? How many have had worried days and sleepless nights wondering whether they were doing what needed to be done to get good care for themselves or for some member of their family? How many have had the experience of being shuttled around from one doctor to another, from doctor to laboratory to X-ray specialist to clinic and back to the doctor again? How many have had the problem of how to pay for all this?

Physicians are inclined to be touchy when one calls attention to problems in organization or in finance. It seems to be difficult for them to appreciate that stating the problem is no criticism of them. No one is responsible; no one did this or failed to do that. Medicine,

which is above all else a profession, fell into a business world and its relations to our changing society just "growed up" like Topsy. The point is that medical service needs a stock-taking; it needs organization. It needs organizing in such a way that the patient knows, first of all, where to go for his service and how to get it. He needs to find the general practitioner, the specialist, the nurse, the laboratory, the X-ray service, the physiotherapist, the hospital and the clinic, and he needs to find them reasonably and harmoniously co-ordinated. Such organizing must be done under professional guidance so that the quality of service does not suffer. And, above all else, organization is needed so each individual practitioner works in close co-operation with his professional colleagues; so he learns from his more experienced or specially skilled colleagues and, in turn, teaches his juniors; so he profits from their experience and criticism and they from his; so the patient receives the benefit of teamwork; and so the service of the group can be steadily improved.

Organized teamwork among practitioners is the basis of high grade practice in our best university medical schools, in our best hospitals, in our best organized clinics. Organization of service needs to be much further extended, until its benefits reach everyone.

Finally, medicine needs organizing of its economics so that the services that are needed can be had without financial burdens and so that the costs are within the means of all who need care. There must be an end of the present situation—"patients without doctors and doctors without patients."

In all this—the adjustment of medical practice, of medical organization and of medical financing—the professions as the producers, the public as the consumers, and the public authorities have duties as well as opportunities. Together, they can not only design but also put into practice a health program for our democracy.

II

THE PROFESSION AND THE BUSINESS OF MEDICINE

A NATION of one hundred and thirty million people, we live across a continental stretch of three thousand miles, in great metropolitan areas, large cities, small cities, in towns and in rural areas ranging from highly modern and improved to quite primitive places. Our land, stretching from the Atlantic to the Pacific and from Canada to Mexico, embraces a wide range of climate and geography. We have millions who know the greatest comforts that centuries of effort, science, art, industry, business, organization, sweat and labor have produced. We also have millions who know little of these comforts, whose conditions of living are slightly, if at all, better than those of people in countries we regard as backward.

It is impossible to set down any single pattern that would describe the way of life of our people or our civilization—or our medical care. At the one extreme, there are the almost unbelievably complex facilities for health and medical services of New York City—thousands of individual physicians, dentists, nurses, pharmacists; two hundred hospitals, official and non-official, with a total of nearly fifty thousand beds; clinics, dispensaries and health centers; elaborate city health and hospital departments; great medical research institutions; and innumerable other practitioners and agencies—all engaged in serving the health and welfare of seven million people

in a city which is the center of a metropolitan area with nearly thirteen million inhabitants. At the other extreme, there are about seventeen million people living in more than thirteen hundred counties which have no well-qualified hospital. Many of these millions live in places where even a single doctor is far off, where a dentist, a nurse, a drugstore, a surgeon, or an X-ray laboratory is not to be thought of in time of urgent need. Between the two extremes, almost every conceivable intermediate is to be found.

Anyone who would have a balanced picture must see American medicine as a whole and must realize it is one thing to know the wonders of modern science and quite another to see science applied to the needs of our people. Despite the wealth and the progressive outlook of our country, for each person who is well served there is probably at least one as yet without benefit of modern medicine.

Like many important components of our American society, medicine is primarily a field of private practice, private initiative, and private purchase—but only *primarily*. Medicine is also public medicine, state medicine, socialized medicine for one-sixth or 25,000 of the 160,000 physicians in active practice. These are salaried employees of government agencies, health departments, public hospitals, clinics and medical organizations of many kinds.

Each year about five thousand physicians are graduated by the seventy-seven medical schools with high standards.* These physicians are well equipped by training to practice. Each has had from two to four years of academic background, four years in the medical school, and at least one year of internship—post-graduate training in a properly equipped hospital. Some, in addition, spend from two to five years in further internship, hospital residence or specialized training. This makes a minimum of seven years and a far longer maximum. Once in practice, the physician must constantly continue his education, at least informally, for the remainder of his

* There are still many physicians in practice whose training was in the medical schools of thirty or more years ago—many of them little more than diploma mills with low standards of training.

professional career to keep abreast with new developments and new techniques.

To safeguard the public, all of our states have laws of licensure. Although immeasurably better than a generation ago, some still need improvement. Beyond the basic qualification of licensure, how can people know how to choose a physician? The only persons really competent to judge a physician's worth are his own colleagues. Yet medical ethics do not permit a physician to speak critically of a fellow practitioner. We see professional judgment in operation, however, in appointments to medical school faculties and to hospital staffs. Because so many hospital staffs are well organized and well controlled, hospital service has been signally better than many kinds of service outside the hospital. It tends to have the advantages of group practice.

Again, anyone who has a competent and upright general practitioner may depend upon his judgment for the choice of a specialist when specialized care is needed. But with the higher fees that specialists can command, the general practitioner is often exposed to the temptation to refer the patient to someone who will split fees, that is, give the general practitioner a percentage of the fee charged. In the highly competitive field of medical practice, the ethics and the ideals of the profession clash with the strain and stress of financial needs, financial interest and—business. Fee-splitting—which is sometimes direct and sometimes indirect—often leads to the extreme that a patient whose condition does not really indicate it is referred to a specialist. Unnecessary operations are one of the well-known consequences.

The complexity of modern practice and the rapidly increasing knowledge steadily add to the need for specialization in many fields. At present, slightly under a quarter (21 per cent *) of our practicing physicians limit themselves entirely to a specialty, and probably

* *Factual Data on Medical Economics.* American Medical Association, 1939.

about as many more devote themselves partially to some specialty.*

There is no legal control of specialization. Anyone licensed to practice can call himself a specialist. The medical profession has recently created thirteen specialty boards, and it becomes a matter of distinction to be approved by any one of them. A certain degree of attainment is also necessary to be elected a fellow of the various specialty societies such as the American College of Surgeons, or of Pediatrics. The public, however, is usually unaware of these distinctions and the individual, if he has no general practitioner to consult, commonly depends on the advice of a friend in choosing his specialist.

The logic of everything that characterizes modern medicine—its complexity, its constantly changing knowledge and skill, its steadily increasing need for specialization, its growing dependency upon specialized equipment and technicians—calls for practice by a well-organized group. Only the conservatism and inertia of medical leadership, made up of older men content or anxious to leave the *status quo* unchanged, stands in the way. We continue to train our medical students in the techniques of well-organized group practice in the medical school, hospital and clinic, and then thrust them out to practice by themselves—until such time as group practice will replace individual practice.

In some states there is a much greater concentration of physicians than in others, and physicians are much more numerous in cities than in rural areas. In 1937, at the one extreme, New York State had one physician for each 507 persons; at the other, Alabama had one for each 1390. To a certain extent, concentration in the cities is necessary and logical, particularly for specialists who can serve a large number of people and who need to be near hospitals and medical centers. Additional factors which attract the physician to the city are the better opportunities to earn an adequate income, and

* Based on the study of physicians' incomes by Maurice Leven, summarized in *The Costs of Medical Care* by I. S. Falk, C. R. Rorem and M. D. Ring, Chicago, 1933, pp. 222-24.

the absence of the difficulties of long travel to see scattered rural patients.

The distribution of physicians is determined more by the ability of a community to support them than by the true need for their services, and the problems of distribution will not be solved until practice in rural and semi-rural areas is made more attractive both professionally and financially. This matter of distribution must not be confused with the adequacy of our supply of physicians. A study made by the Committee on the Costs of Medical Care * showed that even if all of our physicians were working to reasonable capacity, we would still need more physicians for the people of our country to receive the volume of medical service they need.

Physicians' incomes are not, on the whole, very large, and like the incomes of other people fluctuate with the times. In 1929,† the average net income for a physician in private practice was $5,700 or about 60 per cent of the average gross income of $9,500. This 40 per cent differential was absorbed by the expenses of private practice, such as equipment and its obsolescence, office and assistants, telephone and transportation. The increase in the size of the fee which a specialist or a partial specialist charges is reflected in income. For the general practitioner in 1929 the average net income was $3,900 (gross, $6,400); for the partial specialist $6,100 (gross, $10,000); for the complete specialist $10,000 (gross, $16,300).

There is tremendous variation in individual incomes. A few very large incomes raise the general average. The average fails to show, for example, that for each physician who earned more than $10,000 net, two earned less than $2,500 net. Length of time in practice, the size and wealth of the community, the economic level of the patients, the personality and reputation of the physician are factors in this variation.

For the simpler services the fees of the general practitioner usually

* Based on a study of "The Fundamentals of Good Medical Care" by Roger I. Lee, M.D. and Lewis Webster Jones, Ph.D., summarized in *The Costs of Medical Care* by I. S. Falk, C. R. Rorem and M. D. Ring, Chicago, 1933, pp. 222-24.

† *Ibid.*, p. 206. Again, based on the study by Maurice Leven.

become standardized, but for other services the sliding scale is the rule—the practice of adjusting charges according to the patient's ability to pay, a large charge to the rich and, for a comparable service, little or nothing to the poor.

Those physicians who are greatly concerned about the burden of free care overlook the economic implications of the sliding scale. Physicians who follow this ancient practice have always justified the higher fees charged the rich by the lower fees or lack of fees charged the poor, and both public opinion and the law courts have sustained them. According to this doctrine, the one fee is just as much a fair fee as is the other. There is much care furnished without a fee, but under the sliding scale there is no such thing as "free care" from the point of view of the physician. The rich man charged $1,000 for the removal of an appendix and the poor man charged nothing are each being charged a fair fee. Service to each according to his need; charges to each according to his ability to pay.

Those who know even the elements of medical economics know that the sliding scale is not useful in many situations. It is scarcely useful to general practitioners and can be practiced only in a limited measure by many specialists. Most physicians—and certainly those who practice largely or wholly among people of small means—can slide the scale only downwards. Furthermore, a method of charging fees in good times, when many patients do not find it difficult to pay medical bills and only a small percentage of the population is indigent, breaks down when from 10 to 30 per cent (as at the present time) can pay little or nothing. As a result, for those physicians who can charge only modest fees to most of their patients and little or nothing to the poor and who do not collect all of their charges, the burden of free care has become very heavy, and many physicians have incomes so greatly reduced that it is hard sledding to get along.

To allow the physician—a private individual—at his discretion to tax the rich for services rendered to the poor, by use of the sliding scale, is not only distasteful but often inequitable in modern times

when it is difficult or impossible for a physician to know who is rich, who is poor and who is indigent.

Formerly the physician knew his patients intimately and had a valuable, confidential relationship. It is important that the physician should know the patient, his family and social background, his mentality, his fears and worries, his manner of living; for all of these are factors in accurate diagnosis of many ailments—the first essential of successful treatment. But it is also necessary to explain that such a personal relationship is largely a thing of the past under present-day conditions, especially for the people of our large cities, or those who must move about from place to place, or those who are served by busy specialists. The nature of modern life and the growth of medical specialization have already rendered a continuing personal relationship between doctor and patient difficult if not impossible. The problem today is not so much to cling to personal relationship as to restore it.

Doctors have had great influence through their professional societies. The most important organizations have been their local medical societies—usually county societies—in which membership is open (with certain exceptions, some of which will be noted later) to all duly qualified doctors, licensed and ethically acceptable to their colleagues. Local societies are component parts of state societies which in turn are parts of the national society, the American Medical Association.* In addition, there are various specialty societies, many of which devote themselves exclusively to the scientific aspects of medicine.

Most of the work of the AMA has traditionally been concerned with standards of medical service, and it is difficult to overstate the great public service which the AMA and its constituent societies have performed. The reform of medical schools, following the epochal study made by Mr. Abraham Flexner for the Carnegie

* From this point on, *American Medical Association* will frequently be abbreviated to *AMA*.

Corporation; * developing and encouraging high standards of education and of hospitals; standardizing drugs and medicines; fighting quacks, charlatans, patent medicine sellers, unethical and dangerous practices; encouraging research; publishing scientific magazines; advising on legislation; and a host of other professional activities have won for the AMA a deservedly high place in our society. The accomplishments of medicine in America are due in a large measure to these professional activities of high-minded and devoted physicians who have given themselves unsparingly and unselfishly to the ideals of their profession and their societies.

For these reasons it is all the more unfortunate that the AMA and many of its constituent societies now endanger their place in public esteem by engaging in activities more appropriate to a trade than to a professional organization. True, the constitution of the AMA includes among the Association's objectives (in addition to its nobler purposes) "safeguarding the material interests of the medical profession." But the Association, or some of its officers, has stooped to tactics beneath the dignity of a professional group and sometimes below elementary standards of decency and integrity to obstruct changes in public medical relations uncongenial to those who control the society. More on this point later, but here it need only be emphasized that the notable and successful professional contributions of the medical societies are not to be less admired because of the economic and political activities of some of the societies. We must recognize in the activities of the medical societies the same conflicts between professional ideals and financial interests that confront individual physicians trying to practice a profession in a business world.

What has been said about physicians and the practice of medicine applies generally to dentists and the practice of dentistry. Dentistry is a younger profession, and in its educational attainments, its skills

* *Medical Education in the United States and Canada,* Carnegie Foundation for the Advancement of Teaching, Bulletin No. 4, 1910.

and its ethical codes it has not yet quite caught up to medicine. Dentists are making strong and, on the whole, successful efforts to develop professional standards.

Dentistry is only just moving out beyond its mechanical stages, and the public is just beginning to understand and to put proper value on good dental care. Although dental decay is the most prevalent disease of man, dental care, other than extractions and the simplest services such as fillings, is still largely a luxury service. Good dental care is, by its nature, comparatively expensive and it is obtained in substantial measure by less than a third of our people at most. The rest get little dental care except for relief of pain, and extractions. So great is the inadequacy of dental service that the approximately 65,000 dentists we now have would be quite insufficient if financial arrangements made it possible for people to afford the dentistry they need.

Dentists follow, in general, the lead of physicians in their professional standards and codes. And the same is generally true of the relation between the American Dental Association and the American Medical Association. The ADA has tended even to follow the lead of the AMA on the economic and political fronts, though not so vigorously or so blatantly.

In this review I have dealt chiefly with physicians and only briefly with dentists. There are, of course, other worthy groups of practitioners—such as nurses, pharmacists, optometrists, laboratory experts and others—who would deserve attention in a longer review. For the purposes of this book, I do not need to examine the conditions under which they practice.

I hope this review of medical practice as a profession and a business has been sufficient to picture a group engaged in an essential humanitarian service, but momentarily trapped in the meshes of a transitional period. Medicine is still seeking to adjust itself to a business world, in a period when most of the world is groping for answers to the problems this highly industrialized era has created.

III

HOSPITALS—AND TRUE NEED

Hospitals are centers for the practice of modern medicine. It is quite true that not bricks and mortar and scientific equipment, but skilled doctors and nurses are the essentials of good medical care. Yet it is equally true that the equipment and organization and the opportunity for service provided by a good hospital are also essential to the services of skilled practitioners.

What would modern surgery or modern obstetrics or modern medicine be without modern hospitals? What would become of all the wonders of X-ray diagnosis and treatment, refined and precise laboratory tests or the diagnosis of obscure ailments, without the skill and equipment of the roentgenologist or the laboratory technician? Of course all of these provisions can be, and in some places are, developed outside hospitals, but usually in much less complete form and at higher cost.

Hospitals were once little more than pest houses or places where people went expecting to die rather than to be cured and to live. Today they are centers where the patient expects to receive the best and most hopeful care that modern medicine can give. For people who live in small and crowded apartments in congested cities, the hospital is the place to turn not only for the services of physicians, but also for equally valuable skilled nursing.

Our hospitals represent a large capital investment, over three

billion dollars. About one-half is supplied out of tax funds by Federal, state, county and city governments, and about one-half is furnished by philanthropic gifts or through private investment.* Most of the capital invested in non-governmental hospitals has come from philanthropic organizations or from church and fraternal groups. A relatively small part, less than one-tenth, is private capital invested by individuals, partnerships, hospital corporations or industrial companies. More than 90 per cent of the total capital investment is public money, whether directly invested from tax funds or indirectly through community campaigns, philanthropy or charity for non-profit purposes.

With minor exceptions, the American public owns the hospitals. They are built for public use and those who manage them have a trust for which they are accountable. In general this public trust is scrupulously observed and discharged. Here and there, this responsibility is abused, and—as we shall see later—the professional relations involved in hospital organization have sometimes been used for professional and political ends. Sometimes, and in some places, hospitals are constructed where they are not really needed; sometimes they are built more extravagantly than is wise; sometimes hospital trustees feed their own vanities, seek public recognition and acclaim. While all these things occur, they are the exception rather than the rule; they are overshadowed by the wise, devoted, unselfish and generous opportunities for public service which hospital development and management offer.

We have between six and seven thousand hospitals in the United States. Most of them are private, that is to say, non-governmental, hospitals. The exact number is difficult to state, because so much depends upon the definition of a hospital—whether small and meagerly equipped places and certain classes of rest or convalescent homes are included. About one-fourth of the institutions authoritatively accepted as hospitals are governmental. For example, of the

* *Business Census of Hospitals, 1935* by E. H. Pennell, J. W. Mountin and K. Pearson. U. S. Public Health Service, 1939, p. 38.

6,166 hospitals registered in 1938 by the American Medical Association, 4,438 or 72 per cent were non-governmental and 1,728 or 28 per cent were governmental institutions. These proportions become quite different when measured in terms of beds available to serve patients. In the same year, there were 1,161,000 beds in these registered hospitals (not counting over 50,000 bassinets) and of those only 346,000 or 30 per cent were in non-governmental hospitals and 815,000 or 70 per cent were in governmental hospitals. In other words, though more than two-thirds of the *hospitals* are non-governmental, less than one-third of the *beds* are in these non-governmental hospitals. The explanation is that non-governmental hospitals are, in general, much smaller than governmental hospitals.

The hospitals of our country admit about nine and one-half million patients a year and have about one million bed patients under care. In addition, the clinics and dispensaries receive about thirty million visits a year.

To understand the hospital situation, it is necessary to keep in mind not only the control or ownership of the hospitals, but also the kind of hospital. Mental and tuberculosis institutions account for more than half of all our hospital beds, and these are almost wholly owned by government—Federal, state, city or county—and we shall see later that they are almost wholly tax supported. If the phrase "public medical service" or "state medicine" or that other confusing phrase "socialized medicine" is used in connection with hospitals, obviously about 70 per cent of our hospital service is already "state medicine" or "socialized medicine."

Why is tax support so extremely developed for mental and tuberculosis care? The answer is simple. A long time ago, the community had to take over the responsibility for the care of the insane and the tuberculous who were dangerous to the rest of the community.. As mental care became more and more humane and as diagnosis and treatment of the tuberculous became increasingly important, elaborate and expensive, neither individuals nor families could do the job. Government had to step in, and it did. Moreover, nobody

seriously objected. Taxpayers realized they had to carry the burden because nobody else could. Physicians were agreeable because, in general, mental disease and tuberculosis care were too expensive for the individual; and when government invaded these fields of medical practice it was taking over a largely profitless area.

General hospital care, closely allied to the day-by-day practice of individual physicians, has remained largely the field of private, philanthropic, church and fraternal activity. We find that the general hospitals are chiefly non-governmental; the governmental hospitals account for only about one-sixth of the general hospitals and about one-third of the beds. The non-governmental general hospitals are divided into two classes—non-profit and proprietary. In 1935 the non-profit hospitals—often called the "voluntary" hospitals—were 51 per cent of all general hospitals and contained about 55 per cent of the 451,000 beds, averaging 100 beds each. The proprietary hospitals owned by private individuals or partnerships, not limited as to profit making, are, in general, small, averaging about 30 beds each and accounting for less than 46,000 beds.

To understand the usefulness of hospitals to the public we must consider their location, their occupancy, their finances and the quality and type of service they are equipped to give.

For judgment of quality we will accept for present purposes the standards of registration developed by the American Medical Association because, except for a few states or localities, there is no official licensing or registration of value.

The availability of service must be measured in terms of beds, not of hospitals. When a patient needs hospital care, what he needs is a bed in a qualified institution; and unless such a bed is available, the mere presence of a hospital is of little use.

The average of 7.62 beds per 1,000 persons, for all kinds of hospitals, does not show the tremendous variation among the several states. There are as few as 3.57 beds per 1,000 persons in Alabama, 3.58 in Arkansas and 3.59 in Mississippi; and as many as 10.25 in Rhode Island, 12.05 in New York and 12.28 in Massachusetts. There

is even more variation among the different kinds of hospitals.

There are many conditions which govern the number of hospitals and hospital beds a state should have; the most important is the amount of sickness requiring hospital care. Other important factors are density or sparsity of population, distances, conditions of roads and the time required to get to a hospital and also the severity of the climate at different seasons of the year. The fact is, however, that what determines how many hospital beds are available is, with few exceptions, the wealth of the people in the state.

Mental and tuberculosis hospitals do not need to be located in every community; relatively few but large, well-located institutions may meet the entire need of a state. General hospitals must be near where people live. The county is, therefore, important in the study of facilities. A special survey for the year 1936 * showed that 1,288 or over 40 per cent of the 3,074 counties of the United States do not contain a registered general or special hospital. To be sure, many of these counties are not populous, yet nearly one-third have fifteen thousand or more inhabitants and, altogether, the counties without hospitals have about seventeen million people.† It is not necessary for every county to have a general hospital; there may be a hospital readily available nearby, *but it is necessary for the people in every county to have hospital services available.* Otherwise, these people are condemned to something far less than modern care.

More essential than a hospital to a community is the use of the hospital beds. It is shocking to discover that the poorer the people of a state, the fewer the hospital beds to serve them, and that also those beds are actually less used.

Although mental hospitals are used on the average throughout the year to about 95 per cent of their capacity, and tuberculosis hospitals to about 87 per cent of their capacity (both of these, it will be recalled, are principally hospitals supported at public expense), the

* *Hospital Facilities in the United States.* U. S. Public Health Service, 1938.
† Report of the Technical Committee on Medical Care. H.R. Doc. 120, Washington, D. C., 1939, p. 41.

general hospitals are used only to about 69 per cent of their capacity. General hospitals are considered to be efficiently used when they average about 80-83 per cent occupancy.

The U. S. Public Health Service survey showed that the governmental hospitals run at considerably higher occupancy than the non-governmental. The county and city hospitals run at the highest rates; many of them are overcrowded and care for more than a reasonably complete load. When occupancy of hospitals is examined by states, it is found that the utilization of hospitals is greater in the wealthier than in the poorer states.

We have two facts of fundamental importance. The wealthier states have more hospitals and use them at higher rates of occupancy; the poorer states have fewer hospitals and use them at lower rates of occupancy. Obviously, this is not a logical situation, because poor people have more sickness and need more medical and hospital care than wealthy people. The only explanation of the facts is that people have hospitals and use them if they have the money to pay.

The U. S. Public Health Service survey for 1935 showed that the people of the United States furnished about $707,000,000 a year for the support of our hospitals, and the hospitals operated at a deficit because they spent approximately $715,000,000 to meet their costs and expenses. The total expenditures are equivalent to about $5.55 for each man, woman and child in the country. Exclusive of expenditures for the hospitals supported and controlled by the Federal Government, it amounts to slightly less than $5.00 per person.

Although there are more beds in mental hospitals than in general and special hospitals, the expenditure for the mental group is only about one-third as large. This is due to the lower cost per bed of maintaining mental patients than general medical and surgical patients.

More than half of the income to support general and special hospitals comes from patients, whereas patients pay directly only 16 per cent of the incomes of tuberculosis hospitals. This is another

way of showing how extensively some forms of hospital care are already public services.

Among the several states there are wide variations in the sources of the money that supports the hospitals. For example, for the support of general and special hospitals for the country as a whole, exclusive of the Federal hospitals, the general average of income derived from patients' fees is 62 per cent. Hospitals of these types in Oklahoma obtained 94 per cent, and in Alabama 92 per cent of their income from patients, with only 4 and 1 per cent, respectively, from taxes.* These states are among the lowest in number of beds per 1,000 persons and in percentage of occupancy. At the other extreme, patients furnished only 46 per cent of hospital income in Louisiana, 49 per cent in Rhode Island, 50 per cent in New York, 51 per cent in Pennsylvania and in New Jersey; and these states, except for Louisiana, are high in beds per 1,000 persons and all of them are high in percentage of occupancy. Plainly, adequacy or inadequacy of hospital facilities and of hospital use is closely related to the source of income.

The best available professional standards show that we should have at least 4.5 general hospital beds per 1,000 persons, 4.8 beds for mental disease per 1,000 persons, and 2.0 beds in tuberculosis institutions per annual death from tuberculosis. Where these standards are met and funds are available from public or private sources to pay for the use of the beds, these numbers are certainly not too many. By these standards, we need in the United States the following numbers of additional hospital beds: †

General	180,000 beds
Mental	130,000 "
Tuberculosis	50,000 "

The construction of these needed hospitals would cost about 1.1

* The remainder of their income comes from other sources, charitable gifts, endowments, etc.

† Report of the Technical Committee on Medical Care, p. 46.

billion dollars, or roughly, about one-third of the present capital investment in the hospitals of the country.

In summary, this brief analysis has brought out three major points:

1. We have areas and populations that are without modern hospital facilities and services. Our national interest demands that we should meet these deficiencies by building the hospitals and making the services available, especially in the rural and semi-rural areas where the deficiencies are marked.

2. If a community has wealth, it is more effective in equipping itself with qualified hospitals and using them than if it is poor.

3. We have many hospitals which are now inadequately used and the principal reason is dependency on individual patients' fees. We should remedy this situation by developing methods of financing hospital care that do not depend upon the individual patient's ability to pay at the moment when hospital care is needed.*

It should be emphasized that these conclusions are not contradictory. Unused beds in one community are no help in other communities that are without hospitals. We need both *better utilization of existing facilities in some communities and the development of new facilities in others.* Here, as elsewhere, we must keep clearly in mind the distinction between true need and effective demand; hospital need is determined by the amount of sickness and the need for care, but effective demand for hospital care is influenced in no small measure by ability to pay as well as by need.

The problem of providing adequate hospital care to areas and population groups now inadequately served is primarily financial and economic. If we believe that our democracy can bring adequate health service to all our citizens, we must undertake to solve this financial and economic problem.

* For recent developments in insurance against hospital costs, see p. 62.

IV

MEDICAL CARE HAS ITS PRICE

If you need medical care for yourself or a member of your family, you must buy it and pay for it. Medical care is a private service to be obtained by private purchase. To be sure, there are extensive public services, provided through health, hospital and welfare departments; hospitals, clinics and dispensaries and many other provisions. Nevertheless the purchase of medical care is still mainly a matter of private and individual action.

We spend each year about 3.25 billion dollars for all kinds of health and medical services, private and public, equal to about $25 per person in our entire population. In more prosperous years, like 1929, we were accustomed to spend half a billion more, about 3.7 billions or approximately $30 per person. The sources of the money spent in 1936 were as follows:

Total	*100 per cent* *
Patients	80
Governments	16
Philanthropy	2
Industry	2

Despite great increases in public services which have been developed in recent years, patients pay 80 per cent of the national medical bill as private expenditures, or about 2.6 billion dollars, equal to an average of $20 per person in 1936.

The average private expenditure of $20 per person for practi-

* These figures are taken from *Health Insurance* by Louis S. Reed, New York, 1937, p. 19.

tioners, drugs, dentistry, hospitals and nursing is misleading because it conceals the fact that these expenditures are on quite different levels for people in different walks of life. The following figures are taken from a basic study published by the Committee on the Costs of Medical Care,* showing the private medical charges incurred in families of various income groups from 1928-1931:

Income group	*Average charges per person*
Under $1,200	$11
$1,200- 2,000	15
2,000- 3,000	22
3,000- 5,000	30
5,000-10,000	56
10,000 and over	115

For all income groups, the average was $24 per person in that period, 1928-1931, but note that families in the lowest group incurred charges less than half the average and those in the highest group nearly five times the average. This range, as we shall see, reflects the facts that the higher the income, the higher the fee, and *vice versa,* and that the higher the income the more medical service is purchased, and *vice versa.* All of these figures, like the preceding, include charges for all types of medical care.

These average charges for all kinds of medical care purchased privately amount to about 4-6 per cent of family income. One might say, looking at the averages, that medical service is a minor item in the family budget, secondary to food, rent, clothing and transportation. Viewed in this way one might wonder why many people find medical costs burdensome and why there is so much concern and complaint about medical costs. A moment's reflection gives the answer. If sickness costs came in average amounts, the average cost figures would show correctly the drain on individual budgets. But sickness does not come in average amounts—except by chance—and

* The detailed study by Falk, Klem and Sinai is summarized in *The Costs of Medical Care* by I. S. Falk, C. R. Rorem and M. D. Ring, Chicago, 1933, p. 601.

the average figures do not give a correct picture of the burdens created by medical costs.

The unequal financial burdens of sickness are illustrated by the following example * for families with annual incomes between $1,200 and $2,000:

Total annual charges per family	*Per cent of families*	*Per cent of total charges*
Under $60	69	24
$60-100	13	15
100-250	13	29
250-500	4	20
500 and over	1	13

Notice that, at one extreme, 69 out of each 100 families in this group incurred during a year a charge of less than $60 and these 69 per cent carried only 24 per cent of all the charges incurred by all the families. At the other extreme, 1 per cent carried 13 per cent of the total financial burden, and 5 per cent had charges of $250 and more and carried 33 per cent of the total costs. Obviously it makes a tremendous difference whether a family in this low income group is fortunate and has only small sickness costs during the year, or is unfortunate and has large costs. The situation shown by these figures for the people in the $1,200-$2,000 group is duplicated in lower and in higher groups.

The point has been well stated by the Technical Committee on Medical Care: †

> . . . Though free and part-pay services and facilities have been extensively developed, especially in the large cities, though physicians give generously of their services, and though governments have greatly increased tax support for services furnished to the poor, the fact remains that large costs still fall on small purses.

The crucial point is in that quotation. The burden of medical costs arises from the fact that sickness falls without regard for the financial resources on hand to meet them. Indeed, there is a per-

* *The Costs of Medical Care,* p. 114.
† *Proceedings of the National Health Conference,* Washington, D. C., pp. 56-57.

versity in nature; the heaviest burdens of sickness fall on those least able to bear them. There is more sickness and disability among the poor than among the rich. For example, the study made by the Committee on the Costs of Medical Care among representative family groups (1928-1931) showed an average of 3.8 days of disability per person among those in families with annual incomes of $3,000 or more, and 8.9 days of disability among those in families with $1,200 or less. The National Health Survey made by the U. S. Public Health Service in 1935-1936, covering 2,500,000 persons, gave the same story; there was 57 per cent more serious illness (that is, illness disabling for a week or longer) among the poorest families than among the wealthiest. Numerous other studies, as well as these, show that the poor have more illness and are sick longer.

To what extent poverty brings sickness and to what extent sickness brings poverty is difficult to say. We know that poverty brings sickness when food is inadequate, when housing is bad; we also know that sickness brings poverty and dependency when the wage earner is laid low and the family resources are gone. It is futile to argue which is first and which is second in importance, or to run around the vicious circle.

Not only do the poor have more sickness and longer illnesses, but they also receive less care. Nor is this merely a contrast between the poor and the rich; there is a regular sequence from the poor to the rich. The figures on the volume of services received by people in various income groups are shocking. For example, consider the following annual figures per person taken from the Committee on the Costs of Medical Care:

Income group	*Physician services for sick persons*
Under $1,200	1.9
$1,200- 2,000	2.0
2,000- 3,000	2.3
3,000- 5,000	2.7
5,000-10,000	3.6
10,000 and over	4.7

Sick persons in the highest income group received two and a half times as much service as the sick in the lowest group. For dental services, the range was 6 to 1. Among the wealthiest, only 14 persons in each 100 were found to go through a year without medical, dental or eye care; among the poorest, this was true of 47 persons in each 100. Only the volume of hospital care tends to show independence from the income factor, especially in the larger cities where free services for the poor are extensively developed. The National Health Survey and other studies amply confirm these facts, revealing that the less money people have, the less care they receive, regardless of the fact that the less money, the more illness and the greater need for care.

Inadequacy of medical care is, of course, determined in some measure by lack of public knowledge as to when and how to obtain care. Also, there is almost general ignorance about the value of care that may be available in the community. Most people are still unaccustomed to periodic check-up examinations; many still neglect to have themselves or their children immunized against diseases we know how to prevent; large numbers make their own diagnosis and go to the drugstore instead of to the doctor; and some are prejudiced or opposed to medical service. But the fact remains that fear of the cost is the most important cause of delay, neglect or failure to obtain proper medical care.

There are millions of people who simply have not money enough to pay for the medical services they need. If they are among the poor who are assisted by public welfare agencies or private charities for their subsistence, they may also be aided for their medical needs. But, except for relatively few communities, medical services for the dependent poor are woefully inadequate.

Tens of millions above the level of the dependent classes may have enough income for subsistence but still lack means for medical care. These are generally people who never take a "means test" or a pauper's oath for public or charitable aid; they are too proud to seek or accept free care and will go without care—except in the

direst circumstances—rather than ask for it free from a public agency or from a private physician.

Above these income groups, there are more millions who could meet their individual costs if they had to meet the average costs for people in their income groups. These people take in their stride inexpensive illnesses, but their budgets, their savings and resources are inadequate for an expensive or a chronic illness in the family. For them, the only way to avoid the specter of sickness costs is by some arrangement that will average the costs for them—that is, a plan that will distribute costs among groups of people over periods of time. Then, and only then, can each person or family obtain medical services at average costs.

Medical care has its price, but not everyone can pay it. The American Medical Association recently published a chart and commentary which very nicely summarizes ability to pay for medical care.* This says the indigent are "a community responsibility" for their medical services. Next, above them, are shown the people who are not indigent but who have incomes below $1,500 a year; these people are admitted to have "variable needs for economic and medical assistance" when they have minor illnesses and to be the "most important economic and medical problem group" when they have major illnesses. Above them, are shown the people with incomes of $1,500 to $3,000 a year; these are said to be "for the most part self-sustaining" for minor illness and "largely self-sustaining but sometimes needing help" for major illness. These last two groups, the "below $1,500" and the "$1,500-$3,000," are said to present "more of an economic than a medical problem" when they are faced by chronic illness. People with incomes above $3,000 a year are regarded as "self-sustaining—no special arrangements needed."

This is a very interesting analysis of ability to pay for medical care. The pamphlet points out that

> The diagram . . . is designed to show, in general, the relation between medical problems and economic status. The income limits used

* *Factual Data on Medical Economics*, 1939. Chart XXIX, p. 66.

are illustrative only and should be raised or lowered somewhat according to the cost of living in the community under consideration, the number in the family and other economic and social factors.

The diagram indicates the type of medical needs and the economic status which, combined, are responsible for individual or family medical problems. The diagram also suggests the organization of medical services that might be required by different economic conditions, and the limits within which any changes in present conditions might be considered as desirable.

I do not hesitate to say that this chart, except for prevention (which I have not mentioned) and the part dealing with institutional care, and the accompanying text which I have quoted offer a sensible and realistic picture. Indeed it is, as far as I am aware, the first real recognition of the economic problems in medical care that has come from the American Medical Association. But even this chart fails to take account of one fundamental set of facts: It makes no mention of the proportions of the population in each of the income groups. The full implications of the chart become evident when the economic distribution of our population is taken into account. For this point, I summarize the figures presented a few months ago to a U. S. Senate sub-committee * by Arthur J. Altmeyer, Chairman of the Social Security Board, using income classes to correspond with those shown in the AMA chart:

Income group	*Per cent of total population*
Indigent	17.1
Non-indigent and up to $3,000	75.4
Total below $3,000	92.5

Even if we were to ignore the people with incomes above $3,000, many of whom are badly stricken by expensive illnesses, we still have about 92.5 per cent of the population acknowledged by the AMA to present economic problems for the receipt and purchase of medical services.

* The sub-committee of the U. S. Senate Committee on Education and Labor considering the Wagner Health Bill. *Hearings,* Part 3, p. 706.

There can be no escaping the conclusion that medical care has its price and that, in good times as well as in bad times, large proportions of our fellow citizens cannot pay that price. Some are so poor that they must be assisted by the general resources of the whole community. Others may need some public aid, but they could manage for themselves if they were protected by some arrangement against catastrophic costs. We shall see in the following chapters what various responsible groups have proposed to solve these and related problems.

V

THE "CCMC"—AN EXPERIMENT IN DEMOCRACY

The economic and professional problems of medical care reviewed in the preceding chapters have long burdened and perplexed our nation. They were with us in good times; they are still with us in bad times. Here and there, in one place or another, in one year or another, partial solutions have been found. The first systematic effort to tackle the problems nationally and comprehensively was made by the Committee on the Costs of Medical Care, known as the "CCMC." Its history, its work and what befell its report is essential to an understanding of the present situation.

The unsatisfactory state of medical economics led to lively discussion and correspondence of an informal nature in the early 1920's. In April, 1926, some fifteen leaders in medicine, public health and the social sciences came together for a conference to discuss the problems. The greatest need seemed to be a careful survey and analysis of the facts. They were confident this would lead to solutions.

This, it must be remembered, was in the 1920's when Americans had great faith in surveys, facts and the objective methods of science to solve perplexing social problems.

The group that came together early in 1926 was not yet prepared to decide upon a plan of action. A Committee of Five was appointed

by them to investigate the problem further. They explored the subject with a large number of lay and professional people. The response was almost unanimously in favor of organizing a new agency to undertake the task. In May, 1927, a group of representative citizens—physicians, health officers and social scientists—met and organized the Committee which was originally named the Committee on the *Cost* of Medical Care. Its first reports of its program led to some confusion; it was soon dubbed the "Committee on the *High* Cost of Medical Care." Many physicians thought the research program was to deal only with the cost of physicians' services and there was open hostility and criticism. The name was therefore changed to the Committee on the *Costs* of Medical Care, to emphasize the plurality of the types of services being studied.

The Committee of nearly fifty members conscientiously devoted itself for a period of five years to the analysis and studies of the research staff. At the conclusion of its work in November, 1932, the Committee numbered in its membership fifteen physicians and two dentists representing private practice; six public health experts, four of them physicians; ten members selected from institutions and special interests—industrial medicine, life insurance, nursing, pharmacy, hospitals, the American Medical Association; six from the social sciences; and nine representing other public interests.

The CCMC was generously supported by unrestricted grants from eight philanthropic foundations which provided about $750,000 for the entire undertaking. In addition, numerous other agencies collaborated with the Committee by making special studies and researches, generally at their own expense. Throughout the five years, the Committee had full control of its funds and full responsibility, through its Executive Committee, for the research staff and the program of study.

Ray Lyman Wilbur, M.D., was Chairman of the Committee—a distinguished physician, a former dean of the Medical School, and later president, of Leland Stanford University, a past-president of the American Medical Association, and from 1929-1933 Secretary

of the Interior in President Hoover's Cabinet. The Chairman of the Executive Committee was C. E. A. Winslow, Dr. P. H., Professor of Public Health in Yale University's School of Medicine, one of the public health leaders of the country.

The research work was conducted by a competent staff, with Harry H. Moore, a medical economist, as Director of Study and with I. S. Falk, Ph.D., as Associate Director in charge of research.

The program of studies was addressed to three broad questions:

I. What data are now available showing the incidence of disease and disability requiring medical services and what are the established facilities for providing medical and related services?

II. What do existing medical services cost the people and what income is received by the professions and institutions furnishing such services?

III. What organized facilities for medical care exist and how do they compare in adequacy and economy with unorganized services?

The outcome of this program was twenty-six research volumes; the Committee's Final Report; a series of fifteen smaller reports, called *Miscellaneous Contributions;* special publications from the American Medical Association, the American Dental Association, the Metropolitan Life Insurance Company, the National Bureau of Economic Research, the National Tuberculosis Association, the Milbank Memorial Fund and the Julius Rosenwald Fund.

I cite this at length because the work of the CCMC was probably unique and was the forerunner of other significant studies including that of the Committee on Economic Security and the Technical Committee on Medical Care which will be considered in a later chapter. Here was the American and the democratic way of seeking a solution for a great social problem by careful study under the auspices of a voluntary group who worked scientifically, dispassionately and objectively. As a result there was built up the most complete body of information on medical care and medical economics ever available in this country, or probably in any other country of the world. I venture to say that the science of medical economics had its foundation in this undertaking.

When the Committee was organized, it deliberately included within its membership people representing all important points of view, and so it was not surprising that the recommendations were not unanimous. The Committee's Final Report is signed by a majority group of thirty-five members, and a minority report is signed by nine members. In addition there was a second minority report signed by two dentists, and there were two separate personal statements.

The first recommendation of the majority was that medical service should be furnished by organized groups of doctors, dentists, nurses and other practitioners, preferably in connection with hospitals, rather than by separate and individual practitioners. This was the Committee's answer to the problem presented by a large volume of information showing the chaos and lack of organization in our medical facilities and services. Group practice instead of individual practice is essential, the Committee said, if people are to receive modern medical care. The majority explained in some detail how group practice could be developed in different types of communities in order to reduce costs and improve the quality of care. The Mayo Clinic is the best known example of organized group practice in the United States.

Second, the majority of the Committee recommended the expansion and greater financial support of basic public health services. This proposal resulted from the evidence in the studies that public health services are inadequate and insufficiently financed. The Committee had found that we spend only three cents for the prevention of disease for every ninety-seven we spend for treatment and cure. With the realization that an ounce of prevention is worth at least a pound of cure, much more should be spent for prevention so that less will be needed for cure.

Third, the Committee recommended that the costs of medical care should be paid by groups of people instead of by individuals, that this should be done through the use of insurance, taxation, or both. This was not meant to stop the continuation of medical serv-

ice on an individual fee basis for those who prefer it. The Committee recognized that only a small fraction of the population earns enough money to afford individual fee-payment for needed medical care.

The method of solving the cost problem, the Committee realized, depends upon the type of community, the social and economic groups to be served, and the scope of the medical service to be provided. Twenty-two members of the thirty-five in the majority group preferred voluntary to compulsory insurance, eight members believed "that the industrial states at least should immediately begin to plan for the adoption of legislation which will require all persons in certain income groups, certain occupations, or certain areas to subscribe for health insurance." Five members of the majority, in addition to the eight who urged compulsory insurance, believed that voluntary and compulsory insurance should be equally recommended. The majority, though recognizing the limitations of voluntary insurance, believed "that the ultimate results will be far better if experience with actuarial and administrative details, and above all the evolution of group practice units capable of rendering rounded medical service of high quality, precede the adoption of any compulsory plan by a state as a whole." All agreed that costs should be placed on a group payment basis, but they were divided on the question of voluntary, compulsory, and voluntary-plus-compulsory procedures.

Fourth, the majority recommended that states and local communities should develop co-ordinating councils or agencies to plan medical facilities and services in a systematic way. Lack of co-ordination was one of the principal defects the Committee had discovered in the present-day provision of medical services. It had found that in most communities there is no "competent agency to evaluate, supplement, and co-ordinate the medical services of the community on the basis of unbiased and thorough knowledge. As a consequence some communities lack various important services, while at the same time they have an oversupply of other facilities and personnel.

Some practitioners or agencies are inadequately utilized while others are overburdened." And they outlined specific steps which should be taken in different types of communities.

Fifth, the majority said that the education and training of practitioners need a thorough overhauling. Doctors need more training in the prevention of disease and stronger efforts should be made to develop trained health officers for state and local health work. Specialization should be restricted to those who are really trained in a specialty and post-graduate training schools should be developed for doctors. Dental education should be on a broader basis; pharmacy should be placed on a stronger professional foundation; nursing, practical nursing and midwife training should be revised; and for hospital administrators there should be professional systematic training.

This was the answer to the fundamental problem of developing practitioners to furnish co-ordinated services of high quality.

Briefly, the majority of the Committee on the Costs of Medical Care said American medicine is good, but it needs to be and it can be much better. We need better trained practitioners, practicing in well-organized groups, emphasizing prevention, supported by stronger public health services, with payment for service on a group basis, and state and local planning and supervising councils to view the situation as a whole.

The majority closed its report with a chapter on "The Challenge of the Future." It emphasized that the recommendations proposed no revolutionary doctrines, but only contemplated building on present day practices and institutions. The two concluding paragraphs of this chapter are so striking and they are still so timely now, seven years later, that I quote them in full:

> Whatever means may be employed the time has come for action. European countries may not have proceeded with the greatest wisdom, but they have acted. Most of them have developed organized systems of medical care. We in the United States, above all other countries, are now in a position to go forward intelligently. With European experience avail-

able, and with the results of the five year program of study carried on by this Committee and collaborating agencies, a body of data is at hand which will enable each community and each state to take wise and adequate action.

Delay can no longer be tolerated. The death rates from cancer, diabetes, and appendicitis are rising threateningly. More babies are dying each year, many of them needlessly, than there were American soldiers killed in the World War. Every year tuberculosis kills its thousands and costs the country more than half a billion dollars. By early application of our knowledge we could double the cured cases of cancer. The venereal diseases still levy a heavy toll of blindness and mental disorders upon the nation. A great army of rheumatics remains untreated without hope of alleviation or cure. Many diabetics still remain without insulin or receive it too late. Human life in the United States is being wasted, as recklessly, as surely, in times of peace as in times of war. Thousands of people are sick and dying daily in this country because the knowledge and facilities that we have are inadequately applied. We must promptly put this knowledge and these facilities to work.

This was the report of the majority of the Committee on the Costs of Medical Care.

The first minority report, signed by seven physicians and one other member, is a document of quite a different kind. Its first recommendation is that government competition in the practice of medicine should be discontinued. Government should provide medical care for the Army, Navy, Marines, Coast Guard and for veterans with disabilities of service origin or veterans with tuberculosis or mental diseases. In addition, government should care only for the indigent and patients with diseases which can be cared for only in government institutions; the promotion of public health was considered a government responsibility.

The relation of this recommendation to the Committee's studies or to the problems it had undertaken to solve was never made clear. Note that in the urge to get government out of medical practice, the minority did not go so far as to advise that government should relinquish tuberculosis or mental care. Quite to the contrary; the government could retain responsibility for the veterans suffering

from these diseases, and even if not connected with war service.

Second, the minority recommended that the government care of the indigent should be expanded, with the ultimate object of relieving the medical profession of this burden.

They did not go on, however, to say that if government takes care of the poor, doctors will surrender the time-honored privilege of charging higher fees to the well-to-do.

Third, the minority agreed with the recommendation of the majority that there should be co-ordination and control of medical services. But the minority urged that all this should be done by the professional societies. There was no mention of public authorities or of informed laymen.

Fourth, the minority recommended that united attempts be made to restore the general practitioner to the central place in medical practice.

This would be reasonable if they had meant the central place in organized medical groups; but they did not endorse group practice.

Fifth, the minority recommended against the corporate practice of medicine.

With this no sensible person would quarrel.

Sixth, the minority recommended that careful trial be given to methods which can rightly be fitted into our present institutions and agencies without interfering with the minority's conception of the fundamentals of medical practice.

This, when explained in their report, is found to be a plea for a very mild form of organized service and organized payment for the care of chronic diseases; but whatever is done must not differ greatly from present individual practice, or else it would be labeled "revolutionary" and not "evolutionary."

Seventh, the minority recommended development of "plans" for medical care by state or county medical societies. They said that they had "tried to make it plain that we are not opposed to insurance but only to the abuses and evils that have practically always accompanied insurance medicine." They then proceeded to state the

"safeguards" which should surround any plan for the distribution of medical costs. The first of these safeguards is what the reader has already been led to expect. "It must be under the control of the medical profession."

With minor exceptions, the minority stood pat; governmental invasion of the sphere of the private practitioner should stop; the individual practitioner should be further entrenched; group practice should be approached fearfully; group payment should be controlled by the medical societies; and there should be no interference with their idea of the forces of "evolution" already in operation.

The Final Report of the Committee on the Costs of Medical Care was made public in November, 1932. What happened then? The mild proposals advanced by the majority, these timid recommendations for voluntary action on an evolutionary basis, were met by a storm of protest. On the day when the report was released it had already been preceded to the desks of newspaper and magazine editors by advance copy of an editorial statement from the American Medical Association, denouncing the report as "socialism and communism—inciting to revolution." And the state and local medical societies of the nation and the public were whipped to fury by releases, speeches, letters, and denunciations in medical society meetings. The extravagant nature of the attack almost surpasses belief; the language used and the pressures brought to bear on those who had signed the majority report were extraordinary in their vigor and their utter disregard for facts, the actual nature of the recommendations, or the common decencies expected to prevail among colleagues in a learned profession or among citizens in a nation where free speech is a constitutional right.

The American Medical Association and numerous medical societies throughout the country formally approved the minority report, and the vitriolic pen of the editor of the *Journal of the AMA* consigned the majority report to "innocuous desuetude."

Instead of the CCMC having laid a basis for calm and constructive action, it opened a wide breach between those content with

existing situations, fearful of anything new, and those who are keen to see a large social problem faced courageously and constructively.

History may record that this was the major contribution of the CCMC. Despite the attempted compromises that failed to make the report unanimous, its reception showed in clear and unmistakable fashion that, short of surrender by all forward-looking practitioners and lay experts, there was no compromise between the progressive and the reactionary forces. Even the mild report that the majority signed opened a breach so wide that all the issues of contemporary economics and sociology could be driven through it. The absurdity of the AMA stand cannot be seen in a more ludicrous light than by remembering that the AMA editor had labeled as "socialism and communism—inciting to revolution" a report prepared under the chairmanship of, and signed by, Dr. Ray Lyman Wilbur, President Hoover's intimate friend and Secretary of the Interior!

We shall see that the CCMC reports did not long languish in "innocuous desuetude." The Committee's research reports, despite some sniping at them from the AMA and its satellite societies, are widely accepted as authoritative sources of information. Upon these reports and the Committee's recommendations, thoughtful people began to experiment cautiously and to examine existing situations.

Though the recommendations of the CCMC were condemned by medical politicians, both the problems and the facts remained. As economic conditions became worse, medical inadequacies grew more acute and the need for action became clearer.

A great American experiment in the scientific and democratic solution of a social problem failed of its immediate purpose but, as we shall see, it did not fail of a long-range purpose. Its five recommendations for the improvement of professional education, development of group practice, expansion of public health services, group payment of sickness costs, and community co-ordination of services and facilities, provide the signposts for the road to progress.

VI

HEALTH INSURANCE—AT HOME AND ABROAD

The Committee on the Costs of Medical Care showed conclusively that the American people need insurance against the costs of medical care. A hundred other studies, before and after that Committee, have shown the same need, but the CCMC is singled out because its careful, comprehensive, and impartial studies put an end to any further need for surveys on this point. The only part of the subject on which additional statistics might have been needed, after the CCMC finished its work, was that dealing with chronic disease and disability. Even this need has now been met by the National Health Survey, recently completed by the U. S. Public Health Service.

There has been enough of surveys and studies. The facts are at hand. What is needed now is not further meditating over statistics but hard-headed work to devise practical solutions.

Insurance is, of course, nothing new to Americans; we are the most insurance-minded people in the world. This is equivalent to saying that where risks are concerned, more than any other people we protect ourselves against unexpected or serious costs and losses by buying the protection which insurance can give us. We insure against death, accident, fire, theft, storm, unemployment, old age, and dependency. And we even insure, to some extent, against sick-

ness and disability. Insurance in general and even insurance against sickness is an old and thoroughly tested American practice. Insurance against medical costs is not a new-fangled idea; it goes back in this country to the pioneering days of the mines, railroads and lumber camps. The recent rapid growth of insurance against hospital costs shows that the public wants such insurance.

Insurance against sickness may be voluntary or it may be compulsory; it may be commercial or co-operative. We have all kinds in the United States. The defect of most of the voluntary forms of health insurance is that they are too narrow and, generally, too expensive.

Voluntary insurance goes back centuries, having first developed out of the trade and guild associations, trade unions, mutual benefit associations, employer or joint employer-employee insurance plans. Commercial insurance policies and many other forms have been extensively developed. Compulsory health insurance we have in the form of workmen's compensation, which is health insurance for workmen against sickness and wage-loss due to accidents or illness "arising out of and in the course of employment." Forty-seven states and the Federal government have workmen's compensation; Mississippi is now the only state in the Union without this form of compulsory health insurance.

It is not generally known that the first compulsory health insurance system in the world was an American development. In 1798, only a few years after the founding of the United States, Congress established the Marine Hospital Service and operated health insurance for American seamen, requiring the payment of small deductions from their wages into a common fund to pay their sickness costs when they became in need of medical care.* This health insurance system operated for eighty-six years, until 1884. In that year the deductions from seamen's wages were dropped. The hospitals were financed in part from tonnage taxes from 1884 to 1905.

* From 1798 until 1870, the deductions were 20 cents a month; from 1870 until 1884, 40 cents a month.

Beginning with 1905, and until the present time, the system has been wholly tax-supported service. Each year Congress makes appropriations to the U. S. Public Health Service to operate the marine hospitals and to provide the necessary care for the seamen of our merchant marine. Health insurance, in this instance, was given up only to be replaced by wholly tax-supported medical care.*

Health insurance for the general population is not a new movement. An extensive campaign to establish it was waged about twenty years ago. As long ago as December, 1912, the American Association for Labor Legislation, which has been one of the strongest organizations for progressive labor legislation in the United States, under the leadership of John B. Andrews and his associates, created its first national committee on social insurance. After extensive investigations, it published in November, 1915, the first draft bill for health insurance. That original "Standard Bill," so-called, was patterned largely after the European systems of health insurance. It received extensive study and discussion. Between 1915 and 1920, eleven state commissions studied it at length. Six of these brought out favoring reports. In 1920, the movement collapsed, owing very largely to the bitter and vicious campaign—much of it a campaign of outrageous misrepresentation—waged by certain insurance companies that were strongly opposed because the bills provided death, as well as sickness and disability, benefits and the companies feared this would cut into their very profitable business.

Additional causes contributing to the failure of the movement were the reversal of the position taken by the American Medical Association from endorsement to opposition, and the hostility of the American Federation of Labor which feared inroads into the welfare and insurance programs of its unions. Indeed, Labor remained on record as opposed to health insurance until 1935 when the AF of L discarded its old and now outworn position and strongly endorsed

* The history of this service is given at some length by Dr. S. L. Christian in the *Public Health Reports,* June 19, 1936.

health insurance. It had learned by this time that labor unions were not generally successful in operating sickness insurance plans. The Congress of Industrial Organizations (CIO) strongly endorses health insurance.

Needless to add, those who plan a modern health insurance program do not now invite trouble with the large insurance companies by including death benefits, despite the fact that industrial insurance (weekly premium business) is exorbitantly expensive and gives little more than burial expenses to the fifty million wage earners and their families who carry this insurance and pay about $742,000,000 a year in premiums.* European patterns are no longer followed closely; but new patterns to suit American needs and conditions have been developed.

Health insurance for the general population is extensively practiced in many countries of the world. It is therefore fitting that when we consider its application to our problems we should examine what health insurance experience has been in other countries. It is a large and complex subject and I can give only a brief review of it here. However, neither its size nor its complexity justifies the large number of inaccurate and misleading statements that have been circulated among the American people by propaganda groups in the pay of people who do not want anything new in the health field.

The background of health insurance has been summarized in the following brief paragraphs † by I. S. Falk, a recognized American authority who has studied the subject in a number of countries:

Health insurance abroad has a long history, reaching into man's age-old quest for security. Before the industrial revolution, the uncertainties and calamities of life were generally due to natural causes or to wars, and to the social instabilities of an agricultural and feudal society. With the coming of the machine age and the growth of cities, new uncertainties appeared. Large classes of people who were without property came to be dependent on small wages and found themselves unable to

* See, for example, *Cash Benefits under Voluntary Disability Insurance* by Elizabeth L. Otey. Social Security Bulletin, Washington, D. C., February, 1939.

† "Health Insurance" by I. S. Falk, *American Journal of Nursing*, May, 1938.

establish individual financial reserves against emergencies. They sought relief from some of the hazards of life by banding together in mutual aid societies. They pooled their resources into common funds which were to provide guarantees against individual needs.

During the first half of the last century this voluntary mutual-aid movement greatly increased in scope; large numbers of social insurance societies developed and came to have millions of members. Nevertheless, the membership remained at a low figure by comparison with the persons who needed protection. The societies were excessive in number, many were small and financially weak, and they were too numerous in the cities and too scarce in the country. In spite of valuable achievements, the voluntary insurance movement remained inadequate as a general method of furnishing protection against the risks of sickness.

In 1883, Germany, where voluntary insurance had become widespread, but was still grossly inadequate, established compulsory sickness insurance for industrial workers. Two years later the scheme was extended to commerce, and the following year to agriculture. The movement then spread rapidly to other countries. Great Britain adopted its National Health Insurance in 1911.

Sickness insurance legislation was held up during the war, but was resumed with fresh vigor after the conclusion of the peace. All systems adopted since the World War have contained compulsory features. France adopted a compulsory system in 1930; Denmark shifted in 1933 from a voluntary to a partially compulsory system. There have been expansions of the systems in many countries. Between one hundred million and two hundred million persons are now furnished substantial protection through existing schemes.

Some fifty countries of the world have health or sickness insurance systems; about half are entirely on a compulsory basis and the others involve legal or economic compulsions in greater or lesser degree; each is peculiar to the needs and problems and conditions of its own country. The principle of health insurance is simple and flexible; it can readily be adapted to the needs of any country or any state that wishes to apply it in an appropriate way.

Compulsory health insurance came in European countries after extensive development of voluntary insurance. The *societies* or *funds* which had administered voluntary insurance were therefore taken

into the compulsory system and were made the administrative agencies. This created many serious and lasting difficulties. Fortunately for us in the United States, such voluntary societies are few and relatively unimportant and do not stand in the way of developing a sound plan—that is, if we do so before the voluntary organizations now springing up begin to claim a "vested interest."

In the European countries the worker who is required to become insured chooses the society he wishes to join. His employer pays the contributions, both his share and that of the employee, through stamps or in cash or by check. These contributions all go into the treasury of the insurance system. If stamps are used, the employer pastes them on the worker's card and the worker turns the card over to his society. Each insured worker has a card or other record showing that he is insured and that his contribution has been paid.

Customarily, all licensed doctors may become practitioners in the insurance system if they choose. The names of those who elect to come in are posted in public places and each worker has the right to choose his own doctor from the list. If the doctor accepts him, a professional relationship is established which is free from business or financial relations. When the worker needs medical care he goes to his doctor to receive it, but the doctor is paid by the insurance fund. The basis of the doctor's pay is negotiated by the insurance system and the medical societies.

One of the points on which American criticism of health insurance, at least in medical circles, is most common and most uninformed is the basis on which the doctors are paid. There is no absolute rule, because in different countries there are varying practices. In Great Britain, the law guarantees to each local panel, or list, of physicians the right to decide how they shall be paid—whether on salary, on a "capitation" basis (so much per person served during each year or part of a year), on an attendance basis (so much per unit of service furnished) or by a combination of methods. In Germany, there is a rather complex method, worked out chiefly by the medical societies, which is a combination of attendance and capita-

tion bases. In some countries, salaries are used whole-time or, more generally, part-time in rural and semi-rural areas.

Each method has advantages and disadvantages. The salary method is probably the ideal. But each method has to be judged according to its effects: Does it stimulate the doctor to give more service than is really needed? Less than is needed? Does it stimulate interest in the prevention of disease and in the continuity of relations with his patients? Does it give the doctor reasonable security and assurance of income?

It is significant that in Great Britain, where the doctors have had the greatest latitude in deciding the method of remuneration for themselves, after years of experience they have in all local districts given up the fee basis and come to the capitation method. I am inclined to believe that the British experience is, on this point, the safest guide. It suggests that the method of payment should be left very largely to the doctors to decide, even though one may be confident that they will be misguided by their "leaders" into making a bad choice at first but will then come to a sensible solution on the basis of experience.

A word about the method of raising funds. Commonly the contributions are equally divided between the insured worker and his employer, but the formula varies. In Germany, the worker pays two-thirds and the employer one-third and there is no contribution from the government; in Denmark there is no employer contribution, but the government, national and local, pays about 25 per cent of the total. In Great Britain the government contributes about one-sixth and the workers and employers share the remaining five-sixths, equally for males and nearly equally for females. There are various other combinations in other countries.

The contributions are, in all cases but one, payable according to the size of wages or salaries, being usually fixed as a percentage of earnings. The exception is Great Britain where a "flat" contribution is paid for all insured persons regardless of earnings. The worker's share is deducted from his pay and is paid by the employer along

with the latter's share. This is, of course, a payroll tax which is now well known in the United States because of its use for old-age and unemployment insurance under the Social Security Act. The unpopularity of these taxes because of their "regressive" nature deserves some comment.

When payroll taxes are levied for old age insurance, a new demand is made on the budgets of wage earners if they have not hitherto been saving the same sum against the needs of their old age. This is supposedly "regressive" because it reduces the purchasing power of wage earners as a class. Whether or not it is, the argument does not apply to the use of the payroll tax for health insurance because workers as a class are already spending, in the aggregate, appreciable sums for medical care. Collectively they are spending approximately the same total portion of their incomes for this purpose, whether their earnings are relatively large or small. A payroll tax for health insurance, therefore, is merely a substitute for current aggregate expenditures already being made by the same class of people, except in so far as any part of the expenditures which workers are already making is shifted under insurance to the employers, and thence to consumers generally, or to general taxation, that is, to taxpayers generally. Thus, the use of the payroll tax for health insurance is free of the commonest criticism of the payroll tax.

Health insurance operates on an annual budget or pay-as-you-go basis. There is no problem of large reserves or of "regressive" savings.

The European systems vary greatly in their scope. In the British system, only the worker is covered and the medical benefits are limited to the services of the general practitioner and prescribed medicines. And it is limited to manual workers and to non-manual workers earning less than £250 a year; the insured worker's dependents are not in the system, nor are specialist, hospital, laboratory, nursing or other services guaranteed. Some additional services, such as dental or eye care, are supplied by societies which have disposable

surpluses. In Germany, the system covers much broader groups of workers; the guaranteed services are broad in scope and most of them are also furnished to the dependents of the insured person. In other countries, the systems vary in one way and another; for the most part they are broader than the British and narrower than the German.

In addition to medical benefits, health insurance generally gives the worker cash benefits as partial replacement of his wages during such time as an insured worker cannot work because of illness. Also, in nearly all systems, the insurance societies may furnish additional services or supplementary cash benefits, or both, to their members when the financial conditions of the funds permit. Government supervises and regulates these practices to assure that the funds are properly used for the intended purposes.

Health insurance abroad is usually limited to low income groups—in some countries to very low income groups. The contributions are therefore low and the funds available to pay for medical services are small. Doctors and other practitioners are paid on a level with fees paid by similar groups in the population. Such health insurance payments in foreign countries should be compared with fees charged not to higher income groups in the United States, but to people in the same walks of life. Such comparisons, wherever they are made, show that the doctors are well off under insurance, and the medical societies of those countries have themselves testified to this effect. American doctors who argue that health insurance should be limited to low income groups do not realize they are arguing for low-pay practice. Perhaps it is significant that this argument comes not from the class of doctors who would have to make their living from insurance practice but from high income specialists occupying the positions of "medical leaders."

Health insurance services are not usually complete; they are ordinarily supplemented by tax-supported services and by private purchase of the services not furnished through the insurance system. There is no single pattern; each country has developed a system

suitable to its own needs. The doctors who practice under the insurance system are not public servants; they are private practitioners, paid for their insurance services out of an insurance fund, and carrying on fee-for-service practice among non-insured persons.

Although health insurance started, many years ago, primarily to pay cash benefits, the trend has generally been to place relatively more emphasis on the medical services and relatively less on the cash benefits. This is a sound development, placing treatment, cure and restoration of health higher than compensation. Yet it is necessary, of course, that the disabled worker shall have income on which he and his family may live when he cannot earn wages. Health insurance has been really a combination of medical-care insurance and disability insurance. There is a strong feeling in this country that, though both are essential, they should not be altogether combined. The main point is that the doctor who treats an insured patient should participate in deciding whether the patient is disabled but that he should not carry the complete responsibility for certifying the worker's disability. The insured worker should be encouraged to select his doctor exclusively for his abilities as a physician, not for a reputation of liberality in issuing certificates of disability.

The propaganda against health insurance in the United States has gone to such lengths that extraordinary tales and criticisms are now circulated as though they were facts. Many people—especially many doctors—have heard this nonsense so often and from supposedly responsible sources that they have come to believe it. It would take a hundred pages to examine these stories in detail, and they are not worth the attention. A few specific illustrations may be sufficient.

It is said that health insurance has increased the amount of sickness or disability. We are told that there are more days of disability per person under the insurance system in Germany today than formerly, or than in the United States. The fact is nobody knows how much disability there is in Germany; the figures quoted are merely days of disability compensated for wage-loss. These figures have increased, not because the amount of disability has increased

but because more of the disability which occurs is being compensated. Originally, compensation was limited to a maximum of three months, even in cases which lasted longer; later, compensation was made payable for six months and even for a year if the disability lasted that long. Of course, the average number of days compensated therefore increased without regard for the amount of disability itself. For comparison with the United States, the critics compare compensated disability among the poor who are covered in a foreign insurance system with the disability among all income classes in the United States. And since there is more sickness and disability among the poor than among the well-to-do, the result is not surprising. A fair and proper comparison, income group by income group, shows that there is probably no more compensated disability among the insured persons of Germany, or some other country, than would be expected—according to American statistics—among people of the same class in our own country.

There is a lot of nonsense going around about the financial troubles of health insurance. The fact is that health insurance has always shared in the general prosperity or the general poverty of a nation, but health insurance has always been financially sound and no one can point to a single authoritative case to the contrary. Anyone, even if he cannot read foreign languages, can turn to the Annual Reports of the Ministry of Health of Great Britain and can see how well the finances of the system have stood up even through periods of grave economic depression.

It is charged that the quality of medical care depreciates under insurance. This would indeed be a serious charge if it were true. The only testimony advanced to support such a serious charge is the gossip or hearsay of an occasional disgruntled European physician or the observations of an occasional American medical politician who goes to Europe for a few weeks to "study" the situation there. When an attempt is made to prove that our sickness rates or death rates *without* insurance are lower than the corresponding rates in European countries *with* insurance, it is notable that the rates

selected to prove the point deal with causes of sickness or death most directly affected by our public health activities or by our relatively high standards of living. For example, our low death rate from diphtheria is a stock illustration. It seems to be overlooked that so far as we have conquered diphtheria in the United States it is primarily an accomplishment of our health departments—not of our private non-insurance practitioners. Does our low diphtheria death rate prove we are better off without insurance or does it prove we are better off with tax-supported state medicine operated by our health departments?

Recently an American political-medico returned from England and almost strangled with indignation over the deterioration of British obstetrics since it had come under the insurance system. Where he got his information is difficult to learn, because maternity care has not been, and is not now, included in the British insurance service.* Also, our own maternal mortality rate is nothing to hold up to the British as a shining example.

It is almost needless to remark that all authoritative testimony is to the effect that health insurance has not only vastly extended medical care for hundreds of millions of people but has also improved it.

In Great Britain, a quarter of a century ago, hardly consulting the medical profession, Lloyd George put the National Health Insurance Act through Parliament while the doctors remained aloof or in opposition until the eleventh hour. Today it is very difficult to find a general practitioner in Great Britain who is not making at least a decent living or one who would consider for a moment abandoning health insurance, the *Journal of the American Medical Association* and other American medical journals to the contrary notwithstanding. Indeed, the British Medical Association and the local insurance committees of doctors throughout the country have gone on record over and over again for extension of the benefits of

* British health insurance does provide a small cash benefit in maternity cases, but not delivery care. Maternity service must be purchased privately.

National Health Insurance to embrace not only the workingman but all members of his family as well, and also to extend the medical benefits to include hospitalization and the services of various specialists.

Witness the following quotations from a statement by Dr. G. C. Anderson, Medical Secretary of the British Medical Association, made in the American press in response to the gross misrepresentation stimulated by the American Medical Association:

> Soon or late, I predict, every modern civilized community must acknowledge its duty to make provision for the health of its members if they cannot secure it for themselves. In America and elsewhere, there are large numbers who suffer from this disability.
>
> I think that, after twenty-two years, we may be said to have passed the experimental stage in Great Britain and are able to evaluate the merits and defects of our health insurance plan. That it has some defects may be freely admitted, but they are emphatically not those which the American Medical Association has thrust into the foreground.
>
> Chiefly, the American Medical Association and its members who oppose national health insurance allege that it has proved to be a failure and detrimental to the interests of both profession and public. It is said that the so-called "panel system" has tended to stifle initiative and reduce all professional service to the same level of mediocrity.
>
> Nothing could be farther from the truth. . . . As a matter of fact most of our physicians are eager for panel service. . . . Without such a steady income many would have found it difficult to earn a living by the exercise of their profession alone. . . .
>
> From the viewpoint of the public, the insurance act has been equally successful and any attempt to represent it as being otherwise proceeds from a misapprehension of the facts. . . . The benefits of the scheme are evident to the public and the public pays its share cheerfully.*

I cannot emphasize too strongly Dr. Anderson's remark that health insurance has defects—what large-scale public service has not?—but they are not those publicized by the AMA.

Health insurance is *not* a system that restricts the patient's free

* Interview published in the *Detroit News,* September 29, 1934, and reprinted in the *Michigan State Journal of Medicine,* December, 1934, p. 689.

choice of doctor. The customary health insurance system permits all qualified doctors who wish to come in to do so; it permits every insured person to choose his doctor from all who are in the system.

Health insurance is *not* free service. You pay for it; but you pay for it through a fair, reasonable and definite premium. And in a comprehensive health insurance system, when you have paid your premium, you have no further worries about costs because the doctor, hospital, nurse and other major costs are paid by the insurance fund.

Health insurance does *not* reduce the quality of care. With one apparent exception which I shall mention later, the medical professions and the competent public groups in all the large health insurance countries of the world have gone on record on this point, over and over again. There is only one apparently responsible group in the world that says anything to the contrary, and that group is the American medical politicians who do not want any change—except relief from the free care of the indigent—in the system of medical fees under which they and a small fraction of their associates are doing very nicely. The members of this group all tell the same stories, in almost exactly the same words—because they get their stories from a single propaganda machine located in a certain place known as "The Windy City." They rarely, if ever, cite definite authority or evidence for their statements; they generally quote one of their own group or some anonymous "correspondent" from abroad.

Health insurance does *not* discourage medical education, research or advancement. Germany has had sickness insurance since 1883; and for fifty years it continued to be the Mecca of medical education, research and training.

Health insurance is *not* socialized medicine. The doctors remain private practitioners in a system of health insurance. It is merely a system of insuring against the costs of medical care.

Health insurance is not a system of regimenting doctors or bringing them under bureaucratic control. Among all the health insur-

ance countries of the world, there is only one where the medical profession complains about regimentation, bureaucracy and lay control—as well as about lowered quality of care. That country is France.

There is an explanation why France is the great exception among the health insurance countries. France tried for nearly ten years to work out and establish a good system of health insurance. She did not get it because the French Medical Association blocked it. It did not suit the doctors. When the public insisted on having social insurance against sickness costs, the doctors finally agreed; but they forced on their legislature a system of their own. This French system is not a health insurance system—it is *medical indemnity insurance,* and it is the only large-scale system of its kind in the world. Under health insurance, the insured person is guaranteed within certain limitations the service he needs and the insurance fund pays for the service. Under medical indemnity insurance, however, the insured person buys his medical care, pays for it himself, and the insurance system reimburses or "indemnifies" him for what he has spent, but of course it indemnifies him only up to specified, limited sums. This is medical indemnity insurance.

Under medical indemnity insurance there must obviously be a complicated and extensive system of check-up and control. Otherwise patients and doctors could drain the insurance fund dry in a short while. It is therefore not surprising that France has the most extensive system of controls of any large insurance plan. The doctors got what they wanted in France, that is, they got what they thought they wanted when they got a system of medical indemnity insurance instead of health insurance.

The French experience with medical indemnity insurance is very important to us in the United States because the hierarchy of the American Medical Association is rapidly misleading many state and county medical societies by urging "indemnity insurance" in this country. They helped to push a law (the Piper-Hampton law) through the New York State legislature in June, 1939, to permit

this type of insurance and they are now organizing a campaign of propaganda to sell it to the public. The importance of watching the fine print limitations and exclusions in medical indemnity contracts should be made widely known to the public. Those who are sufficiently well-to-do to afford these contracts, and tens of millions are not, will find that it is precisely the illness against which they most need protection, namely the expensive illness, in which the limitations of the contract will come into play. One of the important effects of this insurance is to guarantee the fees to the doctor, hospital and surgeon, up to the limits of the contract. The insurance premium, even for limited insurance, must therefore be high because the guarantee of payment must apply even to fees which are unreasonable and high for patients of small means.

Health insurance is a large subject, but it was neatly summarized in an anecdote recorded by Dr. Michael M. Davis:*

> One storekeeper in a Swiss town said to me, when I asked him whether he would be troubled by the doctor's bill for a long illness about which he had been telling me,
>
> "Doctor's bill? Why, I belong to our insurance society. Only the rich have to worry about doctors' bills here."

Health insurance is no medical millennium, but it is a working plan and more than a half century of experience abroad and in this country with workman's compensation has shown that it offers a practical solution to the basic problem of sickness costs and losses.

* "How Europeans Pay Sickness Bills," *Survey Graphic,* December, 1934, p. 615.

VII

OUTLINES OF A HEALTH INSURANCE PLAN

To CLEAR up some of the existing confusion concerning health insurance, I bring together in the following pages some of the considerations which entered into the specifications for a health insurance plan, worked out in detail a few years ago by my former colleagues, I. S. Falk, Ph.D., and the late Edgar Sydenstricker. The text of these outlines is based upon papers which I have published at various times.*

The basic principles of a sound health insurance plan are:

1. Provision of good health and medical care to all who are eligible under the system;
2. Distribution of the costs among groups of people and over periods of time;
3. Adequate remuneration of those who furnish medical care;
4. Flexibility in the scope of medical benefits to permit adaptation to local variations in available personnel and facilities;
5. Exclusion of proprietary or profit-making agencies;
6. Professional control of professional personnel and procedures;
7. Co-ordination with other agencies engaged in health, medical or welfare activities;

*I have drawn extensively on my article "Mutualizing Medical Costs" (published in the *Survey Graphic* for June, 1934), with the generous permission of the publishers, Survey Associates, Inc.

8. Provision for an adequate program of public education concerning the need and the opportunity for medical care;

9. Freedom of all competent practitioners who subscribe to necessary rules of procedure to engage in insurance practice and opportunity for all qualified hospitals and institutions to furnish services for fair reimbursement;

10. Freedom of all persons to choose their physician or dentist from among all practitioners in the community who engaged in insurance practice;

11. Freedom of insurance practitioners to accept or reject patients;

12. No interference of the insurance system with the private purchase of medical service by those who can afford it.

With these principles as a guide we can discern the outlines of a health insurance plan by considering seven questions which are examined briefly here: *

1. SHOULD THE PLAN BE VOLUNTARY OR COMPULSORY?

Valuable experience is accumulated through voluntary insurance, and that is very useful in the establishment of a compulsory system, but European experience shows that all voluntary schemes have served to usher in compulsory systems. Many of the worst abuses which develop under voluntary schemes are, unfortunately, carried over into the compulsory systems and remain to confuse the new administration and to interfere with efficient operation.

The people in the lower income groups, who most urgently need an insurance plan, show the greatest inertia in coming into a voluntary system. The poor, the mass of workers, can be only partly, if at all, covered by voluntary insurance. Voluntary insurance cannot ordinarily protect itself against membership heavily weighted with "bad risks" except by charging high premiums. If insurance is to cover the people whom it should cover, it must be grounded on a compulsory basis so that both good and bad risks are brought in, and so that premiums are kept at a minimum required by sound

* A somewhat more detailed outline to the same general effect appears in the *Report on Health Insurance,* issued by the Committee on Social Welfare, The City Club of New York, March 4, 1939.

financial accounting. The United States has already accepted this principle in old age and unemployment insurance.

2. WHO SHOULD BE COVERED BY A HEALTH INSURANCE PLAN?

In Europe and in America, it has been customary to restrict health insurance to those who earn small wages, generally less than $1,200 a year. All European and most voluntary American systems of health insurance are poor-man's systems. The finances of the systems and the payments to those who furnish services are, therefore, geared to the financial resources of the poor. Only by carrying an excessively large number of patients can the physician earn a decent income in a poor-man's system. The primary purpose of health insurance is not to furnish financial assistance to the poor, but to enable those who cannot buy medical care as individuals to buy it as groups. From this point of view, health insurance in the United States should certainly apply at least to all families with annual incomes of less than $3,000. If there must be some such income limit, there should also be provision for all persons and all families above the income limit to join voluntarily. People without income who receive public support or assistance should be covered in the insurance system by payments from tax funds as premiums paid on their behalf.

It is clearly desirable to co-ordinate an insurance program with other official and voluntary health and medical activities. The necessity for support from tax funds leads to the belief that an insurance system should be organized on at least a state-wide basis.

3. WHAT MEDICAL SERVICES SHOULD BE FURNISHED?

Medical benefits in an insurance program may be divided into two classes: the first to include the basic services—general practitioner, hospital care (where sufficient hospital beds are available in the community or as rapidly as hospital deficiencies can be remedied) and perhaps unusually expensive prescribed medicines; the second to include other medical services, such as those of the medical spe-

cialists, dentistry, home nursing, laboratory and clinic service, home remedies and medical commodities. The first should certainly be mandatory. The second might be made permissive for each community which desires the services, has the means to pay for them and the facilities to provide them, and proposes a plan approved by the proper insurance authority. Services in the second class should be made mandatory as rapidly as the personnel and facilities can be made available and the costs can be met. There is much to be said for uniform provisions throughout a state-wide or national plan, but practical considerations may make necessary some variations in urban and rural areas.

Many studies of health insurance lead to the recommendation that cash benefits to replace wages lost on account of disabling illness should not be provided in this system, if the need can be met by some other form of social insurance. Wage loss compensation is necessary and should, preferably, be provided through some carefully co-ordinated arrangements. There are differences of opinion, however, on this point. Some think we should follow the European practice of combining medical care insurance with disability insurance; others think we should separate the two; and still others propose that both should be developed as an extension of workmen's compensation. It may be sound and necessary to try out different arrangements.

4. How shall practitioners and institutions be remunerated?

It is possible for a system of compulsory insurance to keep the costs of medical services within the means of the public and yet pay the practitioners and hospitals a fair return for the services they furnish. Just how the practitioner is paid could be determined by the organized groups of practitioners in each local area; they could be permitted to choose a system based upon salaries, full or part-time, on annual fees per person or on fees per unit of service. In any case, it should be possible, except perhaps in the poorest states, to pay the general practitioners a sum equivalent to an average of

five dollars per insured person per annum. Thus the general practitioner who serves one thousand potential patients would receive, on the average, a gross income of about five thousand dollars. In addition, the physician should be free to have private non-insurance patients.

Experience shows that the costs of hospital care can be adequately met for a reasonable cost from an insurance fund. In principle, all that is needed is an arrangement whereby the insurance fund agrees to remunerate each approved hospital at a fixed sum for each patient-day of service rendered to insured persons. The insurance risk is carried by the insurance fund, not by the hospital. Such arrangements can be proposed whether the hospitals are owned by governments, by non-profit corporations or by private individuals. The practice of reimbursing hospitals from an insurance fund is already widely prevalent in group hospitalization (hospital insurance) schemes. The basic principles applying to relations between hospitals and public authorities have been carefully worked out by a joint committee of the American Hospital Association and the American Public Welfare Association.

By facing each question on its own merits it is possible to work out similar arrangements for the adequate remuneration of every additional type of practitioner or institution so that it will be mutually satisfactory to the public and to the medical agencies.

5. WHAT WOULD BE THE TOTAL COSTS OF THE MEDICAL BENEFITS?

The medical services of the kinds which we now purchase privately would cost, on the average, about $27 per person. Our present average private expenditure in the United States is probably about $20 to $24, but standards of good medical care call for larger volumes of service than most of the population ordinarily receives. Under a carefully planned insurance system, good medical care could be obtained for very little more than our present average expenditure.

These are only total costs expressed on a per capita basis. It would be impossible and unsound to apply the average cost uniformly to

all insured persons. The total cost indicates the need for from 4 to 5 per cent of earnings to finance the system. The actual premiums if fixed as a percentage of earnings would make payments by the insured group related to ability to pay.

The basic problem is not to find more money than is now spent for medical care, but to find new and better ways of directing customary expenditures into more productive channels. Any system which might adopt less than complete services or which might apply to families under some maximum income limit would, of course, have smaller costs.

6. How should the funds be raised?

In the United States it has long been customary for approximately 14 to 16 per cent of the costs of health and medical care to be financed through tax funds. Services of the kinds ordinarily financed from tax funds—public health, support of tuberculosis and mental disease institutions, medical care for the needy poor—may be expected to account for about 20 per cent of the health budget. We may assume that at least this much will continue to come from tax funds under an insurance program. The remaining 80 per cent might come from governmental grants-in-aid and direct insurance premiums. In European countries it has been customary for the costs to be shared between employed persons and their employers. In our present state system of unemployment insurance the whole cost is, in nearly all states, levied on employers. In our federal old-age insurance the cost is equally divided between employers and employees, though the newest amendments to the Social Security Act indicate that the cost will probably have to be shared also by government eventually. In any case, tradition and practical considerations agree that the costs must be distributed according to ability to pay. In view of the benefits that would result to society, industry and the people of our country, it may be sound to have a three-way division of costs with a share from general tax funds, employers and insured persons. The precise share of each is subject to differences of opinion.

7. HOW SHOULD A HEALTH INSURANCE PROGRAM BE ADMINISTERED?

In any administrative arrangement that may be devised in a state or national system, it seems essential that provision should be made for public supervision of financial and executive problems and for professional supervision of professional personnel and professional problems.

The study of European and other health insurance systems indicates that three types of agencies, closely co-ordinated, should be provided: executive agencies to set up and administer the scheme; a professional agency responsible for problems of education and research and to supervise the quality of professional service; and a judicial agency, combining lay and professional members, to deal with complaints and grievances.

Such an administrative plan must recognize that certain basic services should be made mandatory for all insured persons in the system and that the scope of additional medical services should be determined by needs, ability to pay the costs, availability of facilities and initiative in formulating a program.

European plans for health insurance have never dealt adequately with preventive care, probably because of their origin as disability insurance plans. It seems essential that an American plan should place adequate emphasis upon the prevention of disease. Such measures as periodic physical examinations of all insured persons by their physicians, immunization, prenatal and postnatal care should be strongly encouraged. Furthermore, an American plan should provide for definite co-ordination between the insurance system and all other agencies devoted to the prevention of disease.

The essence of these proposals is that the economic barrier between the individual who needs care and the practitioner who is prepared to furnish it should be removed. Competition for patients between practitioners, between institutions, and between practitioners and institutions should be retained; but competition should depend upon

the quality and attractiveness of the service, not upon the size of the fee. On the broad and unassailable ground that health is the basis of a people's well-being, all who are insured should have the opportunity to receive care according to their need.

Under a health insurance plan the burden of uncertain and unbudgetable costs would be removed from the individual and would be replaced by the average cost for each income group. The uncertainty and inadequacy of professional or institutional income would be replaced by an assured, stable and reasonably adequate return for service. "Free care" would cease to exist for the practitioner or the hospital because the people in each income group would pay according to their means, and premiums would be paid out of tax funds on behalf of those who have no income or not enough for self-support. Excessive specialism could be brought under control because a competent public body, both lay and professional, could determine a fair share of the funds that should be available for the services of specialists. With reasonably adequate funds and with systematic professional supervision, the quality of medical practice could be raised more uniformly than at present to a level worthy of modern medical science.

This outline is substantially that worked out five or six years ago when medical care benefits were of primary concern. Recent developments indicate the importance of devising adequate systems of disability insurance to partially compensate the worker for wages lost during periods of temporary or permanent disability.

VIII

AMA *vs.* USA

The isolation of the American Medical Association and the loss of public confidence in it is a tragic event in American health affairs. Ordinarily, we like to think that the professional association whose membership covers two-thirds of the physicians of the nation should be our principal adviser and guide in medical and health affairs. Why it does not occupy such a position is important to an understanding of our current problems. The chief events and developments leading up to the present confused situation may be briefly reviewed, from the battle between the medical societies and the philanthropic foundations up to the recent indictment of the AMA and certain of its constituent societies by a Federal grand jury in the District of Columbia.

The origin of these events is very old. It goes back perhaps fifty or a hundred years to the time when progressive physicians, lawyers and laymen repeatedly found political doctors and their medical societies opposing public health developments. Always there was the excuse that government (local, state or Federal) would "invade" the field of the private practitioner. Such opposition persisted even when it was blocking development of public health services that would prevent illness and premature death. Be it said to their credit there have always been, and there are today, progressive physicians throughout the land who can be counted upon to fight the good

fight in the public interest. But be it said to their shame there are physicians of another sort, who know how to seize and control the medical societies for narrow and selfish aims.

Before, during, and after the five-year study of the Committee on the Costs of Medical Care, the philanthropic foundations which were engaged in furthering health services had experienced conflicts with the political doctors. After the CCMC report was published and, allegedly, buried by the propaganda of the AMA, a definite attempt was made by some of these foundations to carry forward a movement for the development of health services by careful studies and researches and by the voluntary actions of public groups interested in health. This was supplementary to the efforts then being made in many communities to solve health problems through voluntary action. The essence of these plans, often under medical leadership and control, was to apply the insurance principle to medical or hospital costs.

The AMA gave lip service to the principle of insurance, expressing opposition only to compulsory insurance. But, in one community after another, the AMA endeavored to forestall any effective application of the principle. A local group had only to begin to study and discuss a proposal to bring a visitation from the Chicago headquarters under the guise of advising the local people. The battles that were fought in Dallas, Baton Rouge, Philadelphia, Los Angeles, New York, Boston, Milwaukee have been in the local and national press and do not need review here. Always the AMA officers said the principle of insurance is sound but its application presents insurmountable difficulties.* In many places, however, the developments went forward despite such opposition—especially on the Pacific Coast. A great boost was given to voluntary insurance when, in 1934, the American Hospital Association endorsed group hospitalization (hospital insurance) in spite of the underground opposition of the AMA. The hospitals at that time were facing bankruptcy in

* See, for example, *Change Comes to the Doctor,* by Michael M. Davis, Annals of the American Academy of Political and Social Science, Phila., 1934, p. 63.

many places, and hospital executives in this dire position went ahead in spite of Jove's threatened thunderbolts.

All this was, however, as nothing compared to the storm from the medical societies when some of the foundations began to point out that even voluntary insurance could not do the job and that compulsory insurance offered the only real answer to the nation's health problem. Then was launched a campaign which for virulence and viciousness almost surpasses belief. The pressures that were brought to bear were those that are common among the most insidious political groups. The individuals who were the special targets of attack were abused in medical periodicals and in the press. They were plastered with the well-known "red" label. When this failed, carefully laid plans were undertaken to deprive them of their jobs and their means of research. The threatened, or actual, "milk-bottle" boycott of the Milbank Memorial Fund has been forthrightly described by James Rorty in his book "American Medicine Mobilizes." * This foundation was vulnerable because a considerable part of its capital was invested and much of its income was derived from the Borden milk products, and the President of the Fund was also Chairman of the Board of the Borden Company. A similar attack was organized against the Julius Rosenwald Fund, tied up with the Sears-Roebuck interests, and against other foundations which had supported the Committee on the Costs of Medical Care.

The immediate result sought by the medical politicians was realized. The Milbank Memorial Fund abandoned its program of studies in this field and liquidated its publication plans. The Rosenwald Fund made gifts for the continuance of this work under the auspices of a council of the American Hospital Association and of an independent committee created in New York; the Fund itself dropped out of this controversial medical care field. Several other foundations ran to cover.

There were, however, additional results not sought or anticipated

* New York, 1939, Chapter 9, pp. 116-129: "Tender Milk Bottles, the Boycott that Blocked Health Insurance."

by these medical-politicos. Some feeble accounts of the backstage battle got into the press but stronger stories were printed in the magazines; and much more became known to influential and responsible people. There was a widespread feeling of shame and disgust, inside and outside the medical profession, at the tactics pursued by those medical societies and foundation trustees that had been active in these affairs. And there crystallized a deep conviction among influential citizens in many parts of the country and in many walks of life that if we were to make progress in dealing with our health problems, the job had to be carried forward without great reliance upon the AMA or on many of its constituent societies, or upon the foundations. Confidence in medical leadership was declining to a low ebb.

In 1934, as these developments were marching toward their close, President Roosevelt introduced his social security program, including health insurance as one of the possible developments. The Committee on Economic Security, composed chiefly of members of the President's Cabinet, established a staff for social security studies and planning. At the request of this committee, the President of the Milbank Memorial Fund released from other duties to conduct the health studies I. S. Falk and the late Edgar Sydenstricker. On their advice, advisory committees representing the medical, public health, dental, nursing and hospital professions were appointed to advise and to participate in the formulation of the plans.

The President's Committee on Economic Security delayed its final report to give the doctors, the dentists, the hospital administrators, the nurses and the public health authorities not only every opportunity to be heard but every facility for criticism and suggestions concerning the program under consideration. How did they utilize their opportunity? The dentists helped; the hospital people helped; the nurses helped; and the public health people helped. Each gave intelligent and critical advice and counsel. But the doctors "co-operated" with the President's Committee with a technique which has its own unique effrontery. As I have said in another

place:* While certain of their leaders and officers were in the full confidence of the officials, while the studies were still in progress and while the President's Committee and its staff were still deliberating, the American Medical Association held a special session of its house of Delegates—the first since the World War—and passed resolutions condemning compulsory health insurance and indicating opposition to the social security program. There were members of the Medical Advisory Board, be it said to their credit, who were independent of this action and were not party to this political maneuver.

The AMA and its satellite societies, like ordinary lobby groups, saw to it that floods of telegrams were sent to the White House and to members of Congress to oppose health insurance. They won! Not only were the health insurance proposals worked out by the Committee on Economic Security buried away in an unpublished report, but even the phrase "health insurance" was stricken out of that clause of the Social Security Bill which charged the Social Security Board to make studies and recommendations from time to time. The Administration had tried to avoid what we naively thought was the European mistake of not bringing in the professions at the planning stage. It was repaid in a way that should have taught a deep and abiding lesson.

People wondered how long the real leaders of the medical profession and the rank and file of the various auxiliary professions—dentists, nurses, hospitals and others—would permit the medical politicians, who too often control medical societies and the editorial columns of the journals, to continue to obstruct progress and to delay and forestall sound legislation. A ray of hope to organized medicine emanated from a massive two-volume report issued in April, 1937, the outcome of a study conducted under the skillful direction of Miss Esther Lape for the American Foundation, entitled *American Medicine: Expert Testimony out of Court.* Most strik-

* *Health Security for the Nation,* League for Industrial Democracy, Vol. VI, No. 3, Oct. 15, 1938.

ingly it presents the doctor's dilemma in the testimony of 2,100 representative leaders in every branch of American medicine from every state in the Union, most of them in practice twenty years or more.

The consensus of opinion of the American men of medicine who are credited with the authorship of these volumes is clearly that the doctor "is no longer concerned exclusively with the care of the sick, but also with a guardianship of the health of the nominally well," that "the present costs of medical care are tragically out of reach of a large part of the population." Repeatedly there is the implication that the nation has a stake in the health of its people. This is progress, and much of it is quite obviously contrary to the official views of the American Medical Association. Keep in mind that the authors of this report, with apparently few exceptions, are members in good standing of the Association.

The *New York Times,* commenting editorially on this report of the American Foundation, said:

> Not social workers despised by the American Medical Association but doctors themselves, a veritable "Who's Who in Medicine," wrote the Foundation's report. . . . It is now doubtful if the entrenched officers of the Association truly speak for organized medicine. The 2,000 representative physicians demand far-reaching, socially-conceived reforms in medical education and practice because "the best is not yet good enough." But the Association through its journal advocates a policy of letting medicine evolve naturally (while millions lie ill without adequate care or die because it costs too much to have a doctor) and regards the practice of medicine as a vested interest akin to that of a plumbers' union in the installation of bathtubs or kitchen fixtures. On many a page the Foundation's report refutes a Bourbonism which holds that all's well with the general practitioner, that medical care is adequate on the whole. . . . If, as the Foundation makes it clear, the practice of medicine needs continual revision in the light of new community needs it is evident that social and economic changes cannot be ignored. Yet the American Medical Association would have us believe that the old laissez-faire evolution is good enough today because it was supposedly good enough yesterday.

These two volumes cut the ground from under the medical politicians. The contents are so clearly and so unmistakably authentic, they so clearly represent the views of America's doctors and they are published under such obviously responsible and conservative auspices that they can not be given the usual "red" label or be laughed off by the medical hierarchy.

Hard on the heels of the American Foundation's report there came into being early in November, 1937, a professional group, popularly known as "the 430" because it originally consisted of 430 physicians who organized themselves into a committee and who subscribed to the following principles:

1. That the health of the people is a direct concern of government.
2. That a national public health policy directed toward all groups of the population should be formulated.
3. That the problem of economic need and the problem of providing adequate medical care are not identical and may require different approaches to their solution.
4. That in the provision of adequate medical care for the population four agencies are concerned: voluntary agencies, local, state and Federal governments.

The Committee of Physicians,* its membership increased from the original 430 to over 1,000, including leading physicians from every part of the country and all branches of medicine, has taken aggressive leadership against the entrenched officers of the American Medical Association and is challenging the Association's defense of the *status quo*. This Committee is asking for no revolution in medicine; it is asking only for free speech within the profession on subjects of fundamental concern not only to every doctor but to every citizen.

Revolt against the AMA sprang up in unexpected quarters. In various specialist societies, free speech was demanded for those physicians who disagree with the policies adopted by the House of Delegates of the AMA. This has always been heresy; the adopted policies

* The name was later expanded to *The Committee of Physicians for the Improvement of Medical Care.*

on economic and political questions were allegedly as binding on every individual physician as the Hippocratic Oath and the Code of Ethics. If 51 per cent of the Delegates vote one way, the other 49 per cent must forget their views and accept the majority opinion. To be sure, the majority vote decides the position of the Association, but must it leave no room for dissenting opinions? The AMA points with pride on every possible occasion to its democratic organization. Nevertheless, there *was* no room for dissenting opinions, even on questions which every citizen is entitled to examine for himself. The AMA hierarchy should have seen the handwriting on the wall as the revolt spread, but not they. Whom the Gods would destroy they first make mad.

The AMA undertook to play its usual hand, once or twice again, to interfere with local voluntary efforts to solve medical care problems. The final episode in the chapter is the GHA affair.

Group Health Association, Inc. (GHA) was organized in 1937 by government employees in Washington, D. C., to provide organized medical services on a voluntary insurance basis. The local medical society, certain individuals, the AMA and certain AMA officers participated in an extensive campaign to destroy GHA. They closed the local hospitals to GHA, denied consultations with local doctors to the GHA staff doctors, made it difficult or almost impossible for GHA to obtain qualified physicians for its staff, even succeeded in weakening GHA's ability to keep those who were on the staff and operated a program designed to embarrass and hinder GHA's public relations—all without any question as to the professional standards of GHA physicians or their work. Here were all the usual tactics to destroy what they had not been able to prevent; the usual clash between the business and profession of medicine.

The local fight in Washington was front page news for months on end. It came to a head when a Federal grand jury handed up an indictment that the defendants "unlawfully have engaged in a continuing combination and conspiracy in restraint of . . . trade and commerce in and of the District of Columbia; contrary to the

statute in such case made and provided, and against the peace and dignity of the United States of America."

The defendants include the AMA, the Medical Society of the District of Columbia, the Harris County Medical Society of Texas (one of the GHA doctors was a member of the Texas society), the Washington Academy of Surgery and various individuals—including the Secretary and General Manager of the AMA, the Editor of the Journal of the AMA and the heads of several AMA bureaus. The indictment was appealed and on July 26, 1939, Justice Proctor in the District Federal Court of the District of Columbia dismissed the anti-trust indictment on the ground that the application of the restraint-of-trade provision in the Sherman Act to the medical profession "represents an extreme position which does violence to the common understanding of the word 'trade.'" The Judge held that the practice of medicine is not a "trade." The indictment was dismissed on the additional ground that the court found the indictment faulty: it was lacking material facts and did not adequately inform the defendants of the crime with which they were charged. The Attorney General filed notice the Department of Justice would appeal and may seek a new grand jury indictment.

"But," as the *New York Times* points out in its editorial of July 28, 1939, "even though the A.M.A. has won a legal victory, and even though it may hold its own against a government appeal, the broader problem which led to the Government's action remains."

On September 9, 1939, the Department of Justice carried the case directly to the United States Supreme Court by requesting the court to review Justice Proctor's decision. The Department said: "The public interest will be served by a prompt and final decision as to whether a group organized to provide medical services for its members and the professional men and women who serve the group are protected by the anti-trust laws from restrictive activity by other groups."

Anyone interested in learning the nature of the AMA power and the methods it uses in its attempts to control medical affairs and

economic and political affairs related to medicine, how it controls and influences the policies of local hospitals, how through the medical staffs of the hospitals it can punish a doctor or a group of doctors who violate the edicts of the hierarchy, should read the grand jury indictment and the brief of the United States Government in this case.*

Whether there will be further court action and what it will lead to no one can say. Whether or not the AMA and its satellite societies are guilty of "restraint of trade," obviously they are guilty of failure to serve their proper functions of guiding, leading and fostering health progress in the United States. The Association's political policies are bankrupt. Instead of being wind in the sails which carry us forward they are a dragging anchor. If the people of the United States are to see health needs met and health services advanced, they must follow other leadership. Fortunately such leadership exists, and it is in action despite the AMA opposition.

* *USA vs.* AMA *et al.* Criminal No. 63221 in the District Court of the US for the District of Columbia. Indictment filed Dec. 20, 1938; brief on demurrer filed May 3, 1939.

IX

THE NATIONAL HEALTH CONFERENCE

On the eighteenth of July, 1938, the people of the United States climbed the ridge of a hill and saw on the horizon a health program for democracy. On that day, a well conceived plan first became visible, and within the space of three days, July 18-20, a nation saw how to convert that plan into a practical, working reality.

The occasion was the National Health Conference held in Washington, D. C., called by the Interdepartmental Committee to Co-ordinate Health and Welfare Activities, at the suggestion of President Roosevelt. The Conference was the culmination of years of effort to bring health services and medical care to the American people. Not only were the unmet health needs effectively presented, but also a program to meet them was submitted to the country under such auspices and with such authority that representatives of our citizens showed themselves ready and eager to "get on with the job."

The nation's capital is strewn with the moldering bones of "interdepartmental committees" created to study this and to co-ordinate that. But this one—appointed by the President in August, 1935, "to Co-ordinate Health and Welfare Activities"—had the leadership and courage of Josephine Roche, formerly Assistant Secretary of the Treasury, the skill and strength and judgment of the other mem-

bers: Arthur J. Altmeyer, Chairman of the Social Security Board; Milburn L. Wilson, Under Secretary of Agriculture; Oscar L. Chapman, Assistant Secretary of the Interior; and Charles V. McLaughlin, Assistant Secretary of Labor.*

The Interdepartmental Committee had the invaluable services of the Technical Committee on Medical Care, each of whose five members is nationally known for scientific attainments in his or her respective field and stands in the forefront of leadership for the advancement of the nation's health. They are Martha M. Elliot, M.D., of the Children's Bureau, I. S. Falk, Ph.D., of the Social Security Board; and Joseph W. Mountin, M.D., George St. J. Perrott, and Clifford E. Waller, M.D., all of the Public Health Service.

The Technical Committee had made a careful survey of health conditions, health services and health needs—met and unmet. The members were thoroughly familiar with the accomplishments of recent years. It would be difficult to find five experts who know more about health conditions in the United States than did this group. They spent their time and energy, not in writing a catalog of what has been accomplished, but in a careful analysis of what can be done further to improve conditions. Their interest is in roads ahead rather than in roads behind us. In February, 1938, they filed their report with the Interdepartmental Committee. Then, as one member of the Interdepartmental Committee put it, "The Interdepartmental Committee thought sufficiently well of this report to submit it to the President. He thought sufficiently well of it to suggest it be made available to the public." At that time the Interdepartmental Committee published only a small pamphlet, "The Need for a National Health Program," which reviewed the accomplishments of the past and cited the needs of the day. This publication of thirty-six pages was appropriately bound in green covers; the traffic light was set green for the road ahead toward national

* Surgeon General Thomas J. Parran and Deputy WPA Administrator Aubrey Williams became members of the Interdepartmental Committee in October, 1938.

health. Miss Roche later released the President's letter of March 8, 1938, acknowledging the report and suggesting that the "Committee give consideration to the desirability of inviting at some appropriate time representatives of the interested public and of the medical and other professions, to examine the health problems in all their major aspects and to discuss ways and means of dealing with these problems." The National Health Conference in the following July was the result.

The National Health Conference brought together representatives of all the important groups and all the major forces concerned with the life and health of the American people. Membership was by invitation of the Interdepartmental Committee and, to facilitate discussion, was kept within two hundred. There were about as many more in attendance as "observers." Among the professional groups were representatives from medicine, including general practitioners, surgeons and specialists in obstetrics, pediatrics, tuberculosis, chronic diseases and mental hygiene; nurses, dentists, pharmacists, medical social workers, professors from the medical schools, hospital administrators and public health officers. But this was not merely a gathering of professional people; this was not merely a conference of the "producers" of health services and medical care. The "consumers" were also there. Around the conference tables, seated alphabetically and rubbing elbows with the professional men and women, were spokesmen for labor, for farmers and farmers' wives, for parents and teachers, for social workers, for public welfare administrators, for the press and magazines and the radio, for business, for insurance companies, for religious and other charities and for many others who represent the rank and file of 130,000,000 people.

These representative people had come from all quarters of the country, and not at the expense of the government, to hear what their government proposed. They came to dissect the proposals, to examine the parts as well as the whole and to determine a course of action.

The objectives of the Conference were outlined in simple terms by President Roosevelt himself:

I hope that your Technical Committee's report on the need for a national health program and its tentative proposals will be read and studied not only by the participants in the Conference but by every citizen. Nothing is more important to a Nation than the health of its people. Medical science has made remarkable strides, and in co-operation with Government and voluntary agencies it has made substantial progress in the control of various diseases. During the last few years we have taken several additional steps forward through the extension of public health and maternal and child-welfare services under the Social Security Act, the launching of a special campaign to control syphilis, the establishment of the National Cancer Institute, and the use of Federal emergency funds for the expansion of hospital and sanitation facilities, the control of malaria and many related purposes.

But when we see what we know how to do, yet have not done, it is clear that there is need for a co-ordinated national program of action. Such a program necessarily must take account of the fact that millions of citizens lack the individual means to pay for adequate medical care. The economic loss due to sickness is a very serious matter for not only many families with and without incomes but for the Nation as a whole.

We cannot do all at once everything that we should do. But we can advance more surely if we have before us a comprehensive, long-range program, providing for the most efficient co-operation of Federal, State, and local governments, voluntary agencies, professional groups, mediums of public information, and individual citizens. I hope that at the National Health Conference a chart for continuing concerted action will begin to take form.

Miss Roche, the Chairman, expressed the hope of the Conference:

As we gather to consider the health needs of the Nation and our responsibility for meeting them, we may take courage from the advances on other front lines of attack on our economic and social inequalities. The people of our land are alert and determined that the frequently difficult but ultimately sure and progressive processes of democracy shall serve all the people. We have established the principle that certain insecurities which individuals alone are powerless to withstand must be

met through public action, that human conservation is an obligation of government.

We cannot attack successfully with small change a 10-billion-dollar problem. To carry forward a long-time program of health services and medical care commensurate with need will cost the Government millions, but save the Nation billions. . . . And every dollar spent on a soundly-planned and well-executed program will yield a national saving many times over in future years—a saving in human values, and a saving in actual cash.

All of us realize that time will be required to put a full program into operation. That very fact makes it all the more imperative that there be no further delay in launching an attack on a broad front.

Faced as we are with this great national need, are there any who will permit themselves to plead unwillingness or incapacity to take united action to meet that need? Our presence here this week, is, we trust and believe, the answer.

Miss Katherine Lenroot, Chief of the Children's Bureau, gave a sharp focus to the important problems of mothers and children:

Fortunately, not only are scientific knowledge and skill available far beyond the extent to which they are now utilized, but the experience of the last 3 years under the Social Security Act has laid a foundation for definite and exact planning for expanded services for mothers and children. No leap in the dark is required.

Need for medical care and health service must not be overshadowed by need for economic opportunity or material relief. In planning health service, as in meeting mass disaster, the needs of mothers and children require that they be placed among the first to be cared for. Knowledge is available; administrative and professional skill is at hand or can be developed; constructive relationships are being established between official agencies and professional groups. You are assembled here to consider the ways in which these elements in a national health program can be drawn together, helped to function, and provided with adequate support.

And Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, known for his skillful and courageous leadership in

the fight against syphilis, sounded a caution against technical but sterile discussion:

The significance of this meeting does not lie in the fact that it involves contemplation and discussion of health needs. There have been many such, both under voluntary and official auspices. I believe, however, that there are differences in the present approach which mark a reversal in trend, in that discussion is requested of you as a preliminary to practical action by responsible Government agencies. . . . And I think we shall have action on several aspects of our problem because it would appear to me at the present time that people in general are beginning to take it for granted that an equal opportunity for health is a basic American right. They are thinking just a little ahead of the lawmakers, and even, I fear, ahead of the practitioners of public health and of clinical medicine.

It has been the insistence of the people back home that has pushed through both Houses of Congress, without a dissenting vote, our recent legislation for cancer and venereal diseases. Although the issues have been over-complicated and the difficulties over-magnified, common, ordinary folks are beginning to get the idea that we know how to do a great deal more than is done to keep them well and to cure them when they are sick. Whenever a clear-cut, understandable way of doing this is suggested, they are becoming increasingly articulate in requesting action. . . .

Later Dr. Parran made another statement which is unusually pertinent and significant:

Those of us who are concerned with the progress of medical science usually think that the great events of medicine occur only in the research laboratory or the operating room. We are witnessing here in Washington another kind of progress in medicine—an effort to put medical science to work. The National Health Conference may well be the greatest event in medical science which has happened in our time.

In these few words Dr. Parran expressed what many have felt keenly, and what for years was the really great problem of American medicine. For a long time the outstanding need has been, not so much newer developments in knowledge and skill, as application

of knowledge already acquired and of skill already at hand. No one questions the value of advances which come from the research laboratory or the operating room or the need for more and ever more advance. What everyone asks is something quite different: How much is all this knowledge or skill worth to the prevention of disease that is not prevented? How much is all this worth to the patient who gets no care? What value shall we place on obstetrical skill for the mother who has only a neighbor to help her when her hour of labor arrives? What value has the marvel of collapse therapy for the tuberculous person who is never seen by a surgeon? What value pneumonia serum or the most modern drug therapy for the patient seen just in time for the doctor to sign his death certificate?

Society owes a great debt to those who labor to advance the quality and the value of medical care. It owes no less to those who labor to bring good medical care to all who need it. And the problem of making the necessary arrangements for the application of knowledge and skill cannot be solved in the research laboratory or in the operating room; it must be solved in the statistical office, at the economist's desk, in the convention room where doctors join with others in careful planning, in the halls of legislature, and finally and most important, in the actual process of administering well-designed arrangements to make medical care available to all our people.

X

THE NEED FOR A NATIONAL HEALTH PROGRAM

THERE is no better way to tell of the studies made by the Technical Committee on Medical Care than in their own words. Unfortunately, their report is too long to reprint or even to review in full. An abridged account is therefore presented, lacking most of the details and statistics although preserving, as faithfully as possible, the original meaning and intention of the Committee's report. In all that follows in this chapter it is the Technical Committee, and not the present author, speaking.*

INTRODUCTORY NOTE

The cost of illness and premature death in this country amounts annually to about ten billion dollars, including in this total the combined costs of health services and medical care, loss of wages through unemployment resulting from disability and the loss of potential future earnings through premature death. On an average day of the year, there are six, or possibly seven, million persons disabled by illness. Every year seventy million sick persons lose over a billion days from work or customary activities. Such fragmentary estimates indicate the economic loss resulting from sickness and

*I have used freely the Report of the Committee, *The Need for a National Health Program,* published February, 1938, and its report *A National Health Program: Report of the Technical Committee on Medical Care,* transmitted to Congress by the President on January 23, 1939 (H.R. Doc. 120).

premature death, but they give no adequate measure of the incalculable consequences of ill health.

Do the methods of public health and medical science offer no hope of further reducing the national burdens of illness? On the contrary, the Committee finds that the essential lack consists not in inadequate knowledge but in inadequate funds to pay for services. Indeed, at some points, the professional and technical resources exceed the need, but they are used to less than capacity while people in need go without service. There are economic barriers between those in need of service and those prepared and equipped to furnish it. The essential inadequacy is not in our capacity to produce but in our capacity to distribute health services.

EXPANSION OF PUBLIC HEALTH SERVICES

Some recognition of the necessity for protection of the public health is to be found in the legal enactments of all our states and in most of their political subdivisions. Unfortunately, the existence of a health department does not always indicate that the community has a complete or adequate health program. For example, less than a third of the counties and even a smaller proportion of the cities employ full-time, professional health officers. The village and township health officer more often than not is some local lay citizen who takes time out from his other work to inspect nuisances or tack up quarantine signs.

States expend through their health departments, on the average, eleven cents per capita annually, while some state appropriations fall as low as three cents. A preventive program designed to reach any reasonable degree of adequacy obviously is out of the question with present financial support.

A start toward remedying this situation was made with the passage of the Social Security Act, Title VI, Public Health Work. The relatively small sums of Federal money thus far provided have made possible some leveling up in local health organizations and some improvement of health service generally. However, it should not be

inferred that even in the counties now under full-time health administration the service at present is adequate.

The situation in many of our smaller cities, and in some of the large ones, is almost as bad as that existing in many of our rural areas. There are numerous urban communities throughout the country in which health activities today are under the direction of part-time physicians engaged in private practice or lay health officers, neither possessing training in modern public health administrative practice.

Not more than half of the state health departments are adequately staffed or satisfactorily equipped to render the services which they alone can give, regardless of the extent to which local facilities may be developed.

In addition to strengthening health organization for general purposes, there is need for concerted attack on specific problems of national health. With programs of proper magnitude, practical eradication of tuberculosis, venereal disease, malaria and certain occupational hazards may be expected; marked lowering of mortality from pneumonia and cancer is possible; and in the case of mental disorders, morbidity can be reduced.

EXPANSION OF MATERNAL AND CHILD HEALTH SERVICES

In any plan for a national health program, primary consideration must be given to developing adequate provision for maternity care and for safeguarding the health and growth of the nation's children.

Since the first grants to states for maternal and child health under the Social Security Act became available in 1936, the public health agency in every state, the District of Columbia, Alaska and Hawaii has strengthened and extended its maternal and child health program. Our two-and-a-half years' experience with this program and with Federal grants to states for services for crippled children has made us aware of where these activities fall short and has given us a basis of administrative experience on which we can plan for needed expansion.

The most serious deficiency in the present maternal and child health program is lack of provision for medical care for mothers and children who are so situated that they cannot obtain needed care without some form of assistance from the community.

There is a great and unnecessary waste of maternal and infant life, and impairment of health is widespread among mothers and children. Each year about fourteen thousand women die from causes connected with pregnancy and childbirth; about seventy-five thousand infants are stillborn; nearly seventy thousand infants die in the first month of life, four-fifths from causes associated with prenatal life or the process of birth; and at least thirty-five thousand children are left motherless. Physicians estimate on the basis of experience that from one-half to two-thirds of the maternal deaths are preventable; that the stillbirth rate can be reduced possibly by two-fifths; and that the deaths of newborn infants can be reduced at least by one-third and probably one-half. This would mean a saving each year of more than seventy thousand lives.

The maternal mortality rate in the United States is high, and there has been but slight decline during the twenty-two years for which we have records.

Notwithstanding the progress that has been made in reducing infant mortality in the first year of life, there are still each year some fifty-three thousand deaths of infants in the second to the twelfth months of life. That these deaths are closely associated with economic conditions is too well known to need discussion. In spite of great gains, there are still areas of the country and special groups in the population in which the mortality in this age group is practically as high today as it was for the country as a whole twenty years ago.

In 1936 nearly a quarter of a million women did not have the advantage of a physician's care at the time of delivery. In the same year only 14 per cent of the births in rural areas occurred in a hospital, as contrasted with 71 per cent in cities. For the great majority of the one million births attended each year in the home by a

physician, there is no qualified nurse to aid in caring for the mother and baby.

In the period 1934-1936, approximately ninety-one thousand deaths occurred among children under fifteen years of age from the acute communicable diseases, diarrhea, accidents, heart diseases and tuberculosis. These deaths represent only a small proportion of the total number of children who are affected by these conditions and who, though they recover, may have suffered permanent injury to their health. The proportion of deaths that are preventable is not known, but there is no doubt that many of these deaths and much subsequent ill health could be prevented.

Child health centers and clinics to which parents, otherwise unable to obtain service, may take their children for health supervision or for diagnosis and treatment are still lacking or are insufficient in numbers in many areas. About two-thirds of the rural areas of the country are not yet provided with such centers.

It is estimated that over six children in every thousand of the population under twenty-one years of age are crippled or seriously handicapped who could be benefited or entirely cured with proper treatment. It is estimated that in the northern parts of the country at least 1 per cent of school children have rheumatic heart disease, a condition largely remediable with prolonged care. Approximately 30 per cent of all children under fifteen years of age have defective vision due to refractive errors; about 5 per cent of school children have impaired hearing; and about two-thirds of all school children have dental defects. Widespread inadequacy of nutrition is responsible for many cases of the deficiency diseases in children, for increased severity of much illness and for retardation in recovery.

Great progress has been made under the crippled children provision of the Social Security Act in making available orthopedic and plastic surgical service, hospitalization and after-care. There is need of further provision, however, for the children crippled or handicapped from heart disease, diabetes, congenital syphilis, injury due

to accident and other conditions that require prolonged care to insure recovery or restoration leading to self-support.

In the United States thirteen of the thirty-five million children under fifteen years of age are in families either with incomes of less than $800 a year or on relief. Such families are able to pay but little toward the medical care necessary to meet their children's needs. The problem of providing sufficient care must be the concern of government.

The general practitioner gives, and will continue to give, the largest amount of medical service to mothers and children. However, for dealing with many conditions of maternity, for diagnosing and treating many diseases of childhood and for guiding development of effective preventive measures in a community, the general practitioner frequently needs to consult with a specialist in obstetrics or in pediatrics. There are many areas in the United States where such specialists are not available or are so inaccessible that the cost of consultation service is prohibitive. Well-equipped diagnostic centers strategically situated would fill a great need.

HOSPITAL FACILITIES

No plan to promote the nation's health can be considered complete or wholly effective that does not give due consideration to hospitals. The growing importance of these institutions arises from a variety of causes. Chief among these is the fact that the home and the family structure are less suited to the needs of the sick than they were even a generation ago. As medicine advances scientifically, the facilities represented by a hospital become more essential for accurate diagnosis and proper care. Every indication suggests that this trend will continue and perhaps at an accelerating rate.

General Hospitals—The growth of general hospitals in this country has been closely related to advances in surgery. In the main, the development of these hospitals may be credited to charitable impulse and to private enterprise.

The general hospital is predominantly an institution of populous

centers. Among the counties of the United States, over 40 per cent have no registered general hospital. Most of these counties are not populous, yet nearly one-third of them have fifteen thousand or more inhabitants; and in the aggregate seventeen million people in these counties are without hospitals. Remoteness from metropolitan centers, a very small percentage of urban population, and low tax income also characterize counties without hospitals.

Self-evident, though often overlooked, is the fact that the mere presence of a hospital in a county or one adjoining may have little meaning to underprivileged people unless funds for meeting the costs of service are assured. General hospital service is not available to a very large segment of the population, either through faulty location of the hospital or because the potential patient is unable to purchase service. Specifically, the data at hand show that among 1,737 counties with local general hospitals, 519 have nothing but proprietary institutions; 786 are served by nonprofit hospitals alone or in conjunction with proprietary hospitals; and only 432 counties contain local tax-supported hospital facilities.

People of low income obtain little hospital service except in areas having a reasonable proportion of tax-supported or endowed beds. In small towns and rural areas admission of the poor to bed care usually signifies an acute emergency necessitating surgery. Exceptions to this statement are found in a few counties where local government hospitals, and in a few states where state-supported general hospitals, meet a part of the need.

Tuberculosis and Mental Disease Hospitals—The United States as a whole has sixty-five thousand tuberculosis sanatorium beds and twenty-two thousand beds set apart for the care of the tuberculous in hospitals of other types. As in the case of general hospitals, source of financial support is the main factor determining the extent to which available beds are used. Bed care in tax-supported institutions is, as a rule, furnished without cost to the patient, while the opposite financial arrangement obtains in private sanatoria, except for a fairly significant proportion of persons who are maintained

there at public expense. Since relatively few patients are able to meet the cost of their own care, financial barriers that commonly exist between patients and medical service offer no great handicap to reasonably full use of existing facilities for bed care of the tuberculous. The immediate need, insofar as institutional care is concerned, is for increasing the existing number of beds.

Institutional care of persons with mental disorders may be regarded, for all practical purposes, as a monopoly of state and local governments. Together they operate about 96 per cent of the total beds in mental hospitals. The state government is the principal operating agency, institutions are large and service is organized on a state-wide basis. Governmental hospitals for persons with mental disorders are not only large but they are fully occupied. Nongovernmental hospitals of the same kind are small and less completely filled.

Out-patient Services—Non-bed patients exceed in number those requiring bed care. The hospital out-patient department, commonly spoken of as the clinic or dispensary, has demonstrated many advantages for meeting the needs of the sick poor who are able to come to some central place for care. Aside from lowered service costs that accrue from the volume of work, the clinic brings together specialists representing various branches of medicine at a place where they have access to laboratory services, X-ray and similar aids to diagnosis and therapy.

Even more than hospitals, general out-patient departments are institutions peculiar to large cities. Each of the cities above 250,000 population reports one or more out-patient departments, while only 2 per cent of cities below ten thousand have such resources. It is not until cities reach fifty thousand that more than half of them are provided with this type of service.

MEDICAL CARE FOR THE MEDICALLY NEEDY

The formulation of a national health program implies acceptance of the principle that the maintenance of the health of its

citizens is a responsibility of government. The conservation of national health requires the provision of adequate facilities and services designed to prevent disease, and, when sickness strikes, to secure its adequate treatment; but the lack of a unified public policy creates a barrier to the achievement of this objective.

The majority of the states have laid the legal framework providing for medical care of certain groups of public charges, but the practical results obtained under this essentially permissive legislation are meager due to lack of funds necessary to implement the program. Furthermore, with the exception of a few states, no legal basis exists for the provision of medical services to the self-sustaining population above the relief level, whose financial status, precarious at best, is particularly threatened by the costs of sickness.

There are in the United States today probably forty million persons—almost one-third of our population—living in families with annual incomes of less than $800. It is estimated that approximately twenty million cases of disabling illness will occur in this population during a year, of which a minimum of eight million cases will cause disability of at least a week's duration. Under the conditions prevailing in 1935, about two million of the more seriously disabling illnesses will receive no medical care; and the six million attended cases in this category will include over two million patients in general hospitals.

The uneven distribution of hospitals, out-patient departments, and medical and nursing personnel constitutes a serious defect in our national resources for the maintenance of health. In many rural areas, in which the number of physicians and nurses is low and hospital facilities are limited, rich and poor alike encounter difficulty in obtaining adequate medical care. At the next level of adequacy, represented by small cities remote from metropolitan areas, the poor suffer the effects of limited facilities to a greater degree than the rich. With increasing urbanization, the supply of medical facilities and personnel becomes more abundant for rich and poor, and clinics, visiting-nurse service and tax-supported hos-

pital care supplement the resources of low income families. The wide attention given to the availability of these free medical services to the poor overlooks the fact that their benefits are largely restricted to the poor in the metropolitan areas, who comprise only part of the medically needy population. A large proportion of medically needy persons is found in small cities and rural areas, in which limited hospital facilities, restricted tax support of hospitals, and insufficient medical and nursing personnel create an additional obstacle to the receipt of adequate medical care.

The receipt of medical care depends largely on income, and people of small means, or none at all, though having the greatest need for care, receive, on the whole, the least service.

To what extent does government contribute to the support of medical services for this group? In 1935, expenditures from government funds for health and medical services amounted to about one-sixth of the total medical bill in that year or approximately $520,000,000. Excluding government support of hospital care in Federal institutions, and hospital care of the tuberculous and mentally diseased, total expenditures for tax-supported medical care amount to some $130,000,000 annually.

The inadequacy of this expenditure for tax-supported medical care is emphasized by its comparison with the estimated cost of supplying essential medical services at an emergency level to the medically needy, which would amount to about $400,000,000 annually. This sum would provide only a minimum amount of medical care; a volume of medical service consistent with professional standards of adequacy secured by individual purchase on a standard fee basis would entail costs of approximately five times this amount.

The handicap of insufficient funds severely limits the ability of public welfare agencies to meet the medical needs of the public assistance group. The effective distribution of public medical care is further impeded by lack of established procedures in its administration. The present administration of public medical care is char-

acterized by division, overlapping and duplication of authority, lack of satisfactory policy for the determination of eligibility of care and insufficiency and low standards of medical service.

GENERAL MEDICAL CARE

The Committee placed first emphasis on prevention of disease. Recognizing the importance of private medical practice, of hospitals, clinics, sanatoria, health departments, and other institutions and agencies for the provision of modern medical service, the Committee has recommended a program to meet existing deficiencies.

Preventive services and hospital facilities are necessary but of themselves they are not sufficient. A large proportion of illness is not yet preventable. Only a fraction of all illness requires hospitalization, though many more cases require or can profit from organized clinic service. But regardless of the number and distribution, technical proficiency, and quality of service available from hospitals, clinics, dispensaries, sanatoria, physicians, dentists and nurses, these services are of no direct benefit to persons who do not use them. Society must not only have an armament against disease but must also see that it is effectively used. Between the practitioners or institutions equipped to serve the sick and the millions of people in need of their services stand barriers, the most important of which is an economic wall which both groups are anxious to scale.

The costs of medical care must be brought within the means of the public. Furthermore, insecurity and dependency created by loss of earnings during periods of disability must be reduced as far as available means permit. If a national health program is to bring health security to the population, it must include provision against the burdens created by medical costs and by loss of earnings during periods of disability.

Why do self-sustaining people with low incomes receive inadequate care? The first basic reason is found in the irregular occurrence of illness and of sickness costs. Every substantial study of

medical costs shows that they are burdensome more because of their uncertainty and variability than because of their average amount. And this is equally true for the urban family of the industrial wage earner and for the rural family of the farmer or farm laborer.

The burden of sickness costs is mitigated in some measure by the arrangement whereby fees are adjusted to ability to pay. Nevertheless, the fact remains that large costs still fall on small purses.

The uneven burden of medical costs is the first cause of inadequate care. There is a second cause of great importance. A considerable proportion of the population is too poor to be able to pay, through its own resources, the full cost of adequate care. If they are to receive such care, some part of the cost must be borne by the more prosperous. This is not a new principle; it has long been practiced in the payment for medical care, and the medical profession has always insisted that people should pay for medical care in proportion to ability to pay.

Sickness has become a hazard like death or unemployment in that it entails losses which may be greater than the individual can meet unaided from his own resources. The need for food, shelter and clothing can be budgeted by the individual family; sickness costs can be budgeted only by a large group. If medical care is to be made available to all families with small or modest incomes at costs they can afford, the costs must be spread among groups of people and over periods of time.

Inadequacies in the receipt of medical care are reflected in inadequacies of the incomes of practitioners and hospitals. While doctors are only partly occupied, while nurses suffer from substantial unemployment and while hospital beds stand empty, millions of persons in need of service do not receive it.

Every sound arrangement to reduce the burdens created by variable sickness costs for the public operates to stabilize and increase the incomes of those who furnish the services.

Many efforts have been made, without the help of government,

to solve the problems of sickness costs through voluntary insurance plans, and they deserve high commendation. The proof of their value, however, is not their good intentions but their actual accomplishments in achieving coverage. Voluntary sickness insurance without subsidy or other encouragement through official action may be important as a method of experimentation, but it has nowhere shown the possibility of reaching more than a small fraction of those who need its protection. In the face of needs which are vital and urgent for at least a hundred million persons in the United States, the Technical Committee on Medical Care cannot find the answer to the nation's problem in voluntary insurance efforts.

INSURANCE AGAINST LOSS OF WAGES DURING SICKNESS

On the average day of the year, probably from five to seven million persons are temporarily or permanently disabled by illness. These persons are unable to work, to attend school or to pursue other customary activities.

Among gainful workers, the rate of disability varies considerably, depending on age, sex, economic level, occupation and other factors. Taken by and large, there are probably between seven and ten days of disability per person a year among the gainfully employed, but the figures range from as little as three or four days up to fifteen or more days a year per person in different groups in the population. These figures understate the incidence of disability because they do not fully take account of those who have fallen out of gainful employment by reason of long-continued disability.

We have already pointed out that sickness brings economic burdens not only because medical services involve large and unpredictable costs, but also because disability of the wage earner leads to wage loss. Loss of income in turn makes the purchase of medical services all the more difficult.

Stating the wage loss from disability in terms of averages or of

total costs is significant but also somewhat misleading, just as average or total costs for medical care may be misleading. If each worker had the average annual disability and the average annual loss of earnings, there would be no problem worthy of extended discussion. Unfortunately, a wage earner does not suffer average illness or average loss, except by chance. On the contrary, disabling illness ranges from less than a day to the entire year, and in some cases the disability is permanent. Whether an illness will be mild and non-disabling, or severe and disabling, whether disability will last a day, a week, a month, a year, or the remainder of the individual's lifetime depends upon many factors which in general cannot be foreseen or predicted by or for the individual. Though we can forecast with substantial accuracy what will happen in a large group of workers, the individual cannot know in advance what will happen to him. This is the essential reason why the averages are misleading and why disabling sickness is a constant threat to the security of the individual and the family of small or modest means.

Loss of earning power because of disabling illness is a hazard as serious as unemployment or old age. Society must provide protection against this hazard which threatens the economic and social security of all who are dependent upon ability to work.

XI

THE NATIONAL HEALTH PROGRAM: FIVE RECOMMENDATIONS

Following the procedure used in the preceding chapter, I have abridged the text of the Technical Committee's five general recommendations.* Taken together these present the broad objectives of the National Health Program.

In order that the reader may follow the recommendations more readily, it may be helpful to keep in mind that they are in the following order:

I. A. Expansion of public health services
   B. Expansion of maternal and child health services and services for crippled children
II. Expansion of hospital facilities
III. Medical care for the medically needy
IV. A general program of medical care
V. Insurance against loss of wages during illness

The Technical Committee on Medical Care pointed out that the recommendations are not separate and independent; they are intimately related and interlocked. For example, the fourth recom-

* Adapted from the *Report of the Technical Committee on Medical Care,* transmitted to Congress by the President on January 23, 1939 (H.R. Doc. 120).

mendation is very broad and includes the third which is narrow and limited. The Committee was of the opinion that the first and second recommendations "should be given special emphasis and priority in any consideration of a national health program more limited in scope than that which is outlined in the entire series of recommendations." It also pointed out that the second recommendation, expansion of hospital facilities, cannot be considered apart from the third or fourth recommendations; it would be futile to build hospitals in areas where they are lacking but needed, unless there were also provision to help people pay for the services to be furnished in these new institutions. Such interrelations must be kept in mind throughout.

As in the preceding chapter, what follows is largely in the words of the Committee's report. It is the Committee and not the present author speaking.

EXPANSION OF PUBLIC HEALTH SERVICES

In view of the fact that a good beginning has been made in more recent years toward carrying out health activities through well-planned and directed effort, the Committee proposes (Recommendation 1-A) that Federal participation in state and local health services under Title VI of the Social Security Act be extended through increased authorization for grants-in-aid to the states. Increasing federal participation and leadership should promote the inauguration and expansion of fundamental and accepted health services and the extension of newly developed services requiring special administrative techniques, under state and local operation and control.

The Committee recommends that primary consideration be given to the development of local health organization, with special reference to units for counties and large cities, and to the provision in the state and Federal agencies of consultants who are equipped to serve the local departments. Local health services would be directed by full-time health officers who would have as assistants an adequate staff of trained public health workers. The maintenance

of facilities for the training of additional public health personnel and allied professional workers should continue.

To further the development of a basic health department structure for the nation, the Committee recommends the addition of not less than $23,000,000 annually to the amount now available from all sources—Federal, state and local. This would be utilized largely for providing additional full-time health officers, epidemiologists, public health nurses, sanitary engineers, laboratory technicians and other personnel.

The Committee further recommends that the part of the proposed national health program concerned with the expansion of public health services under the Social Security Act be directed particularly toward reducing disability and premature mortality from certain important causes of sickness and death, with which public health is already equipped to deal in an effective manner through measures of proven value. Especially should efforts be directed against tuberculosis, venereal diseases, pneumonia, malaria, mental disease and industrial health hazards.*

The estimated maximum annual costs of the expanded programs which have been outlined would be as follows:

1. Public health organization	$ 23,000,000
2. Tuberculosis	43,000,000
3. Venereal diseases	47,000,000
4. Pneumonia	22,000,000
5. Cancer	25,000,000
6. Malaria	10,000,000
7. Mental hygiene	10,000,000
8. Industrial hygiene	20,000,000
Total	$200,000,000

This table showing services needed in addition to those now pro-

* At this point in the Committee report, there is presented an outline of proposals to deal with these special problems.

vided under existing appropriations indicates in each instance the total estimated amounts required from all sources—Federal, state and local—at the time when the recommended programs would reach their maximum development. The Committee wishes to make it clear, however, that the estimated maximum amounts are, to a certain extent, tentative in character. It is difficult to forecast very accurately just how much money would be needed for certain programs at their peak of operation. Much more accurate estimates undoubtedly could be made after opportunity were afforded to see how far the amounts estimated and presented here would go in meeting the specific problems. The Committee does not suggest that the maximum amounts recommended for operation at the peak should be made available during the first year. Before these programs can be organized and placed in operation successfully, the necessary technical and professional personnel must be recruited, additional physical facilities provided, and states and local communities must have time to make additional appropriations.

It should be pointed out here that certain programs with which this section of the report deals provide for some services which would be covered to a considerable extent by programs presented in other parts of the Committee's report. To the extent that costs may be duplicated by provisions in succeeding parts of the whole program, the amounts recommended in this section could be reduced if the funds were provided under the other programs.

While the operation of the programs recommended would call for considerable sums during the years of full operation, it need not be assumed that expenditures for all of the items would have to remain at the maximum level indefinitely. Indeed, should the proposed activities prove as effective as it is believed they would, the costs of maintaining services for the control of certain preventable diseases might be expected to be reduced progressively in the future as the incidence of these diseases is diminished.

Of the total amount recommended in this report for the expansion of preventive health services, it is considered proper that the

Federal government might be expected to contribute approximately half for the country as a whole. However, this should not be interpreted to mean that matching necessarily would be required on a fifty-fifty basis in each state. The basis for determination of state allotments and requirements set up for matching obviously should take into account such factors as the extent of each problem, the status of financial resources in each state and other factors that might be given consideration.

It is suggested that in a ten-year program, the probably necessary increases in appropriations by the Federal government for grants-in-aid to the states and for administration, demonstration and investigation, exclusive of the expected state and local expenditures, might start at $10,000,000 for the first year, and gradually increase until a maximum of $100,000,000 was reached at the beginning of the seventh year.

With respect to the administration of such additional Federal appropriations as might be provided, the Committee is of the opinion that the procedure which now obtains in the administration of Federal funds available for grants to the states under Title VI of the Social Security Act might well serve as a desirable guide for the future. It is proposed that the Federal government would continue to provide leadership and technical advisory services which it now offers in addition to financial aid to the states. Plans for the work would be initiated in the state health departments. The actual administration and control of activities carried on within the states would remain, very properly, in the hands of the state and local authorities. The chief function of the Federal government should be that of acting as an equalizing agent among the several states in order to overcome inequality in financial resources and public health problems, to provide the leadership and guidance essential to the successful establishment and maintenance of a properly co-ordinated, nation-wide attack on the important causes of disability and mortality in the country as a whole.

MATERNAL AND CHILD HEALTH SERVICES AND SERVICES FOR CRIPPLED CHILDREN

It is recommended (Recommendation 1-B) that Federal participation in maternal and child health services under Title V, Part 1, of the Social Security Act be extended through increased authorization for appropriation for grants-in-aid to states over and above the $3,800,000 now available each year. Increasing Federal participation should allow for a program to provide facilities for: (a) Medical and nursing care of mothers throughout the period of maternity and of their newborn infants throughout the neonatal period; and (b) health supervision and medical care of children.

A plan of orderly expansion during the next few years, which is compatible with sound administration, and a reasonable program for training personnel, assumes (1) a gradual development of the program of maternity care and care of newborn infants with a view to reaching the maximum Federal contribution as soon as may be possible, but at least not later than the tenth year, and (2) a gradual approach to a general program of health supervision and medical care for children, which would not reach desirable proportions until the full medical care program contemplated in Recommendation III or IV is in effect.

Fundamental to the expansion of the program for maternity care and medical care of children is further increase in the basic local health services, including health supervision of pregnant women and of infants and pre-school children by local physicians, public health nursing services, health supervision of school children and the services of dentists, nutritionists, health educators and medical social workers.

Expansion and improvement of the program should be along three lines:

1. Expansion of facilities for conservation of health of mothers and their newborn infants, including—

Medical care of mothers and their newborn infants throughout the

period of maternity and the neonatal period, including care of the mothers at delivery in the home or in the hospital, and of their newborn infants, by qualified local physicians with the aid of specialized consultants assisted by nurses, preferably public health nurses, trained in obstetric nursing procedure.

Facilities for expert diagnosis and care in diagnostic or consultation centers and in the home.

Hospital care as necessary for medical, social or economic reasons.

2. Expansion of facilities for the conservation of the health of children, including:

Health supervision, medical care and, when necessary, hospitalization of older infants and children—the health supervision and medical care to be provided by qualified local physicians, with the aid of specialized consultants in local consultation or diagnostic centers, or elsewhere when the sick child cannot be brought to the center.

3. Increased opportunities for postgraduate training of professional personnel—medical, nursing and medical-social—will be essential in order to provide qualified personnel to carry out the program. Additional centers for such training, especially for postgraduate instruction, would have to be established.

It is recommended that Federal participation in services for crippled children be extended through increased authorization for appropriations for grants-in-aid to states, over and above the $2,850,000 now available each year for the purpose of meeting the needs of additional children who by reason of serious physical handicap require prolonged care of the kind already provided under existing programs. Increasing Federal participation should allow for:

Increased facilities for orthopedic and plastic services for the care of children who are crippled or suffering from conditions that lead to crippling from diseases of bones, joints, or muscles.

Increased facilities for care of children who are suffering from heart disease, injury due to birth or accident, or other diseases or conditions that require prolonged care to insure recovery or restoration leading to self-support.

This program should be closely related to the proposed expanding program of general health and medical services to children.

The first few years may be expected to be a period of development and equalization of services, and, therefore, one in which Federal financial participation would be relatively large, supplementing present expenditures by states or local communities. Increasing financial participation by the states would be encouraged. In determining the extent to which each state would be eligible for Federal aid, account would be taken of (1) the ability of states to provide for support of necessary services, and (2) the need for maternal and child care as shown by mortality and morbidity rates, present facilities for care of mothers and children, personnel in need of training and facilities for training and the need for services for crippled children as shown by the number of such children in need of care and the cost of providing it.

The opportunity is before us to make a major gain in our provision for the health of mothers and children. The proposed program calls for extension of our health services into all parts of the United States, for an expansion of the program to fill gaps in existing services. It calls for more adequate facilities for training professional workers and for co-operation of public agencies with the medical, dental, nursing and social service professions, to make sure that medical and related services are available to mothers and children of all income groups and in all parts of the United States.

This program contemplates during the first year an increased expenditure by the Federal government through grants to states as follows:

Maternity care and care of newborn infants	$4,500,000
Medical care of children	3,000,000
Services for crippled children	2,000,000

During succeeding years, the program would be expanded gradually, reaching at least by the tenth year a proposed Federal expenditure of $47,500,000 for maternity care and care of newborn infants, $30,000,000 for medical care of children and $5,000,000 for services to crippled children.

HOSPITALS AND RELATED FACILITIES

There are deficiencies in the present scheme of organization which serve to limit the usefulness of hospitals to patients and circumscribe their influence on medical practice. These deficiencies include an insufficient number of institutions and beds, improper location, incomplete services and inadequacy of financial support; they apply in varying combinations to hospitals of different classification. In some degree, recommendations submitted by the Committee regarding public support of hospital care for the needy will bring about greater use of existing facilities. Such action alone would be only a half-way measure; further construction, additions to equipment, extension of services and the broadening of the basis of financial support are indicated. To this end the Committee submits (Recommendation II) that Federal grants-in-aid be provided for the construction of needed hospitals and similar facilities, and special grants on a diminishing basis toward defraying the operating costs of these new institutions in the first three years of their existence.

Since the demand for service in general hospitals is conditioned so largely by ability of patients to pay, local experience with respect to use may not always be taken as a reliable measure of need. This is particularly true of rural areas where so large a percentage of the beds are supported by fees from patients. To bring all state averages up to the standard of adequacy so frequently set by professional judgment, namely, 4.5 general hospital beds per 1,000 population, will require the addition of 180,000 beds. Some of these beds would be added to existing hospitals, but most of them would call for new units to be located in areas now without hospitals or having hospitals whose physical or financial deficiencies preclude their becoming true community institutions. There is need for at least five hundred hospitals in areas largely rural in character. Those would be primarily small institutions of from thirty to sixty

beds. The large number of beds needed for chronic patients should usually be provided in association with general hospitals.

By following the generally accepted measure of institutional accommodations for the tuberculous, namely, beds per annual death, one finds that the ratio for the United States as a whole is 1.15. Ratios for individual states vary from 2.75 down to 0.20; only five states have two or more beds per annual death, while in twenty-six states this figure is less than one. Nine states do not make legal provision for sanatoria; five of these subsidize care at local institutions, but in four states no state-wide provisions are made for hospitalizing patients. Clinical experience has demonstrated that two beds per annual tuberculosis death are required for hospitalization of the tuberculous in areas having a reasonably effective case-finding program. To bring facilities of the whole country up to this standard after allowing for a continuing reduction in the number of deaths, would require the addition of approximately fifty thousand beds. Some of these beds may be incorporated into existing general hospitals and sanatoria, but in several states entirely new institutions should be established.

For the care of patients with mental or nervous diseases, the ratio of beds to population varies with the states from 6.88 down to 1.96 per 1,000 persons. While no absolute figure can be taken to express the needs for institutional accommodations, there is every reason to suppose that provisions already made by states in the upper 25 per cent group are not in excess of actual demand, as shown by the fact that the beds in their institutions are used at an occupancy rate in excess of rated capacity. The lower figure for this group, namely 4.8 beds, may, therefore, be taken as a reasonable standard that is amply supported by experience.

To bring the ratios of beds to population in all states up to this standard of 4.8 would require the addition of 130,000 beds to existing accommodations. Most of these new beds would serve to augment facilities, especially in those states now having insufficient

Hospital facilities in the United States—Present status, needs, and Federal grants for new construction over a 10-year program

Medical type of hospitals	Present status: Number of hospitals	Present status: Number of beds	New beds needed	Proposed Federal grants: Construction	Proposed Federal grants: Maintenance for 3 years	Proposed Federal grants: Total
General	4,566	410,024	180,000	$315,000,000	$108,000,000	$423,000,000
Tuberculosis	1,042	82,591	50,000	75,000,000	30,000,000	105,000,000
Mental	552	531,445	130,000	162,500,000	39,000,000	201,500,000
Total	6,160	1,024,060	360,000	$552,500,000	$177,000,000	$729,500,000
500 health and diagnostic centers						7,500,000
Total						$737,000,000

accommodations. Existing institutions might be enlarged or new units could be established as local circumstances warrant.

Attention is directed to the financial need of newly constructed hospital accommodations of the several classes—general, mental and tuberculosis. Since most of these beds are to be placed in areas with little wealth, states and local communities might encounter some difficulty in taking over rapidly the added financial burden. A special program is therefore contemplated to provide Federal grants-in-aid for the maintenance of new institutions or additional beds during the first three years of their operation. Recommended Federal grants for this purpose are computed on a basis of $300 per bed per annum for general and tuberculosis hospitals and $150 for mental institutions. The aggregate for the nation as a whole is not to exceed 50 per cent of the actual patient-day costs, with curtailment stipulated at each year so that these Federal grants disappear after three years.

If all the hospital construction outlined above were undertaken, these special maintenance grants would involve a maximum total Federal cost of about $177,000,000, distributed over a period of years beginning with the completion of the first hospital and ending three years after the completion of the last institution built under the program.

In another section of the Committee's report, recommendation is made for the payment of public funds to defray the cost of hospital care of medically needy persons. This in large measure should promote the use of unoccupied beds in existing institutions and of the beds that are to be added through the proposed construction program.

MEDICAL CARE FOR THE MEDICALLY NEEDY

It is proposed (Recommendation III) that the Federal government should provide grants-in-aid to the states toward the costs of a medical care program for recipients of public assistance and other medically needy persons. Such grants should assist in pro-

viding medical care for two broad groups of the population: (1) those for whom the local, state and Federal governments, jointly or singly, have already accepted some responsibility through the public assistance provisions of the Social Security Act, through the work relief program or through provision for general relief; (2) those who, though able to obtain food, shelter and clothing from their own resources, are unable to procure necessary medical care.

The program would be developed around, and would be based upon, the existing preventive health services. It would be in addition to the programs and costs involved in Recommendations I and II but would need to be closely related with the services provided under those recommendations. The program contemplated in the present recommendation would provide medical services on the basis of minimum essential needs. It would include medical and surgical care, with necessary diagnostic services, medicine and appliances, hospitalization (exclusive of the period of maternity and the care of the tuberculous and mentally diseased) bedside care and emergency dental care.

The use of non-governmental hospital beds for medically needy persons, paid for on a proper basis by public funds, is presumed as a part of this program wherever local conditions render this policy necessary or expedient. It is taken for granted that the medical and allied professions and institutions will participate in the administration of this program as has been the case in many states and communities.

While the adoption of an annual income of $800 or less as a basis for determining the estimated number of the medically needy has been used in recent studies, this is somewhat arbitrary. On this basis, however, the size of the population to be served, and the costs of the proposed program, have been determined with reference to a total of forty million persons. For future planning, it would be desirable to extend the definition of the medically needy to include families up to the $1,000 level. Local estimates of the

medically needy population will necessarily take into account regional variation in the costs of living.

The annual minimum cost of such essential medical services, hospitalization as specified and emergency dentistry has been estimated at $10 per person in the population served. Applied to the forty million persons, including recipients of public assistance and other medically needy persons, the total annual cost would be $400,000,000. Of this amount, the proposed Federal contribution might amount on the average to 50 per cent, or $200,000,000, to be matched on the average by an equal contribution from the states. Total expenditures—including Federal, state and local contributions—might amount, in the first year, to $50,000,000; in the fifth year, to $150,000,000. While it is estimated that the maximum annual expenditure would not be attained before the tenth year, a more rapid rate of development would bring the program to its maturity at an earlier date.

It must be emphasized that the estimate of $10 per person per year for the cost of providing medical care to the medically needy is based on a consideration of minimum medical needs. Adequate care, exclusive of dentistry, might cost more than twice this amount. Although a minimum estimate, the recommended figure probably exceeds the per capita expenditure for public medical care made by any state at the present time, and is several times higher than the present average expenditure for this group in the country. It must be recalled also that this amount is supplemental to the preventive services already supplied by organized health agencies, and that it will be augmented by the provisions of Recommendation 1-A for expanded public health services, including control of tuberculosis, mental disease, cancer, venereal disease, pneumonia, malaria, and the industrial hygiene program, and by the provisions of Recommendation 1-B for expansion of maternal and child health services.

It should be noted that this program is exclusive of the provisions for maternity care presented in Recommendation 1-B, but in-

cludes its provisions for medical care of children. If the present recommendation be adopted, it would therefore cover the costs of the special program for children presented in Recommendation 1-B.

Since financial resources and the availability of medical facilities and personnel vary from region to region, it is proposed that the $200,000,000 Federal contribution be allocated to the states on a basis which takes account of two factors: (1) the number of the population in each state which is dependent or otherwise medically needy; (2) the financial status and resources of the state. It is assumed that the states themselves will take into account the wide variation in needs and resources among different areas within their own boundaries. Primarily administrative and operative responsibilities would rest with the state governments. Eligibility for Federal grants-in-aid would depend upon the meeting of certain minimum conditions regarding the service to be rendered to dependent and other medically needy persons and upon provision of funds by the states for their share of the costs.

A GENERAL PROGRAM OF MEDICAL CARE

The Committee has reached the conclusion that government must assume larger responsibilities than it has carried in the past if it is to help self-supporting people meet the problems of medical costs.

A program to provide a rational basis for the financing of medical costs cannot start in a vacuum; it must take account of existing customs, facilities and practices. Wide variations in existing personnel, institutions and economic conditions require that a national program must be flexible and must be adaptable to diverse social and economic conditions in different areas of the country. The program must aim at the eradication of socially undesirable differences, but it must recognize that this can be effected only over a period of years. Such considerations lead the Committee to the conclusion that effective operating programs should preferably be designed and administered on a state-wide basis. The role of the Federal government should be principally to give financial and technical aid

to the states in their development of sound programs. Accordingly, the Committee submits (Recommendation IV) that Federal grants-in-aid should be provided to the states toward the costs of a more general medical care program.

The implications of this recommendation may first be examined in respect to programs which may be developed at the state level. If effective medical services are to become a reality, people of small means must be able to obtain these services without facing the costs at the time the services are needed. The costs can be distributed among groups of people and over periods of time through the use of taxation, or through insurance, or through a combination of the two.

Tax-supported public medical services already involve annual expenditures of about $500,000,000 to $600,000,000. The use of tax funds to pay for medical services is, of course, a very old method of distributing the costs. The principle of distribution is, however, applied in an extreme fashion, because, in general, public medical services are available to needy and, more recently, to medically needy persons and not to other taxpayers who provide the funds. A more general program, which would meet the needs of a larger proportion of the population to whom medical costs are burdensome, could be developed through expansion of existing public medical services, provided such services were made more generally available to the population.

Existing public medical services are, broadly considered, of two kinds: (1) general services for the needy, and (2) limited classes or categories of service for special groups in the population. The scope of services for the needy is well known, and the deficiencies are widely recognized. The categorical services are usually highly specialized; they include services which state and local governments have developed for persons afflicted with diseases infused with an element of public danger—the acute communicable diseases—or with diseases which, being long-continued or chronic, or involving highly specialized care, create costs which are beyond the ability

of individual families to meet—cancer, infantile paralysis—or which, because of lack of care, precipitate dependency and large social burdens—tuberculosis, mental diseases.

The expansion of public medical services can be effected, as some think they should, through this categorical approach. On this basis, government would make particular kinds of services available to the public, some only to the needy, some to the medically needy and some to wholly self-supporting persons or to the entire community. Some of the possibilities in these directions have already been discussed; only their expansion to all or most income groups is involved here.

It is fitting to note two objections to the expansion of public medical services through this categorical approach. First, each limited development brings additional administrative and organizational complications because of the diversity of the separate services that are made available, and because of the gaps that remain between them and also between them and privately purchased services. In many of our cities today, the complexity of these categorical services already defies the understanding of even the expert, and much evidence shows the confusion in the public mind concerning what is and what is not available, who is and who is not eligible. Second, the limitation of particular services to particular groups in the population piles up further complexities because of the necessity of investigating the financial status of the person who needs the care. People who are self-sustaining for the other necessities of life have profound objections against a Means Test for medical services, whether this Means Test is administered by a governmental agency, a social worker or by a private medical practitioner.

If functional arrangements are to be simplified rather than made more complex, if medical care is to become available without a Means Test for those who need service, if the public is to have ready access to these services, it seems essential to contemplate expansion of public medical services as a general program and not through a categorical approach. Such a program would produce a

close similarity between public medical care and public education.

Medical care in the United States now costs approximately 3.25 billion dollars a year. Subtracting the amount already being spent by governments—Federal, state, and local—a general program of public medical care for the nation would require about 2.75 billions a year. A program of sufficient size and scope to come to real grips with the national needs would require new tax expenditures of from one to three billion dollars a year. These sums include the expenditures that would be involved in carrying out Recommendation III, which calls for an outlay of about $400,000,000 annually. The possibilities in this direction deserve careful exploration, with special regard for the forms of taxation to raise the necessary funds.

It should be emphasized that the new tax funds for public medical services would not represent a new kind of expenditure by the population; most of these sums are already being spent from private funds. The essential change would be to effect a wider distribution of medical costs by changing the method of payment.

A general program of medical care can also be financed through insurance contributions. Health insurance designed to provide adequate care could be financed principally by direct, earmarked contributions. Like public medical care, health insurance is a method of budgeting expenditures so that each family carries a budgeted, rather than, as at present, a variable and uncertain risk. As is shown by large experience, the insurance procedure is entirely compatible with freedom of all practitioners to participate in the plan, with free choice of physician by the patient and with wide latitude left to physicians as to the method of remuneration.

A health insurance system might properly be limited to individuals under a specified income level, perhaps $3,000 a year, or might cover all persons in specified employment groups through contributions levied on stipulated income. In order that the establishment of an insurance system should not lead to one program for the purchase of medical care for insured gainfully employed

persons and another for non-insured dependent groups, the system should make provision for the inclusion of persons without income through contributions on their behalf from public funds. Thus, tax payments would be used jointly with insurance contributions to support a unified scheme for both self-supporting and needy persons.

A choice between public medical service and health insurance involves many alternative considerations. Public medical service is potentially applicable to whole areas and to entire populations; it can be used wherever the taxing power of government reaches. Health insurance is somewhat more easily applicable to industrial than to agricultural areas, though this limitation is by no means an absolute one.

The two procedures are not mutually exclusive alternatives. On the contrary, each may have substantial advantages for particular areas or for particular portions of the population to be served. The choice of method or combination of methods should, in the opinion of the Committee, be made by the states rather than by the Federal government.

When making decision as to the program to be developed, many states would need to give careful consideration to the unequal financial resources of areas within the state. The same kind of public policy that is the basis for Federal aid to the states dictates state aid for underprivileged areas within the state.

Federal aid to assist the states in the development of sound programs should be equally available to the states for the development of public medical services, health insurance or a combination of the two. Recommendation IV should, therefore, be understood to mean that Federal grants-in-aid to the states should be available within reasonably wide limitations as to the procedure, categories of services or population groups which a state may decide to assist.

It is scarcely necessary to emphasize that the development of a sound state program for medical care need not wait, in states where financial resources are adequate, on the availability of Federal aid.

The cost to the Federal government of a program developed under Recommendation IV cannot be estimated closely until the essential features of the plan are determined. Furthermore, a complete program could be attained only after some years of development. The over-all cost of services to be furnished through health insurance or analogous public medical services, or both, may be estimated to be about $2,600,000,000 a year, assuming a theoretical population coverage of 130,000,000 persons and provision of such services as could, on the average, be furnished for $20 per person. If one-tenth of the total might be made effective in the first year and the Federal share of the cost were assumed to be something between a minimum of one-fifth and a maximum of one-third of the total involved in furnishing services, the Federal cost at the outset might fall between $52,000,000 and $87,000,000 a year. If the grants-in-aid continue to be necessary, the annual Federal cost would presumably increase tenfold in perhaps ten years, reaching an eventual maximum falling between one-fifth and one-third of the 2.6 billion dollars over-all cost.

These estimates of Federal cost include (and duplicate) considerable portions of Recommendations I-A and I-B for the expansion of public health, maternal and child health services and all the cost involved in Recommendation III dealing with grants-in-aid toward medical care for needy and medically needy persons.

Development of public medical services and health insurance through Federal aid such as is suggested above might not be as rapid as may be desired. If this is a meritorious objection to the grants-in-aid plan, more rapid development can be effected through a uniform payroll tax, with a tax-offset arrangement, as in unemployment compensation.

INSURANCE AGAINST LOSS OF WAGES DURING ILLNESS

Under the present social security program, workers are assured some continuance of partial income, in lieu of their regular wages, when they become unemployed and are unable to work. Under

the workmen's compensation laws, most of them are protected against wage loss resulting from accident or injury arising out of employment. But generally they have no protection against wage loss resulting from non-industrial sickness or accident. A limited number of workers do have some such protection through voluntary insurance schemes, commercial or non-profit; but they are a small minority of the total. If the wage earner becomes unemployed for lack of a job, he is insured for some continuity of income between jobs, if he is in employment covered by unemployment compensation; but if he becomes unemployed because he is unable to work, he is thrown back upon such private and individual resources as he can command. Experience has shown the need for more substantial protection.

The Committee therefore submits (as its Recommendation V) that Federal action should be taken toward the development of programs for disability compensation.

There is good reason to believe that the insurance against disability can best be treated not by a single insurance system but by two systems closely co-ordinated. There is, first, the problem of the temporarily disabled worker—the worker who has an acute illness and for whom there is every reason to expect that, after a few weeks or a few months, he will recover and return to work. There is, second, the problem of the permanently disabled worker who, by reason of crippling or chronic illness, will probably never again be able to enter gainful employment. The administrative problems to be met in paying benefits to the first worker are quite different from those which arise in the case of the second worker, and there are important reasons for believing that the rate of benefits provided through insurance should not be identical. An arbitrary line may be drawn between temporary and permanent disability, defining the first, for example, as disability lasting less than twenty-six weeks and the second as disability lasting more than twenty-six weeks.

Temporary-disability compensation, patterned after unemploy-

ment compensation, would involve a cost of approximately 1 per cent of wages. With a substantial but not unreasonable waiting period, seven, ten or fourteen days, this would probably support benefits calculated at 50 per cent of wages for a maximum of at least twenty-six weeks. The allocation of the cost may have to be different from that which is customary in unemployment compensation.

Permanent-disability insurance, with benefits geared to old-age benefits, would probably cost 0.1 to 0.2 per cent of wages at the outset and the cost may be expected to rise in the course of years, attaining a level between 1 and 2 per cent of wages in twenty years and perhaps between 1.5 and 3 per cent a generation or two later, the exact cost depending upon the benefits provided and upon numerous other factors.

A disability compensation program is not primarily part of a medical-care program. Nevertheless there are important interrelations between the two. The cost of compensation for disability would be needlessly high if wage earners generally did not receive essential medical care. Hospitalization and other institutional care, and vocational rehabilitation for workers who are disabled, are essential if those who can be restored to working capacity are to receive the necessary care. Without such facilities and services, the cost of invalidity annuities would be unnecessarily burdened. These and similar considerations indicate some of the interrelations between disability insurance and a general health program.

XII

DISCUSSION AT THE NATIONAL HEALTH CONFERENCE

WHAT was said at the National Health Conference by the invited representatives of public groups is second in importance only to the report of the government's committee. A complete record was kept of the proceedings and has been published by the Interdepartmental Committee.* It is a large pamphlet of 163 pages, of which 48 pages cover the speeches by the government officers and the Report of the Technical Committee, and 115 pages are taken up by the speeches and remarks of the conference members. The discussion from the floor gives ample evidence that representatives holding different views were invited, and were given opportunity, to express themselves.†

I wish it were possible to reprint here the entire text of the conference discussions, but through quotations it is possible, I believe, to give the substance and the flavor of the remarks that were made during those three days when representatives of government, of specially interested public groups and of the professions had an

* Proceedings of the National Health Conference: July 18, 19, 20, 1938. U. S. Govt. Printing Office, Washington, 1938.

† The index of the Proceedings lists 99 speakers, of whom 87 were others than those connected with the government committees.

opportunity to express their views on the problems of extending and improving health services for the American people.*

The following paragraphs are only partial quotations, and many of them embody slight changes that were made in the official summary for purposes of brevity and continuity.

Dr. Irvin Abell, President of the American Medical Association:

It is the history and tradition of the medical profession—as recognized by our President in his message to us this morning—that it stands ready at all times to give of its utmost in raising the standards of medical education and the quality of medical service, and in extending the benefits of its knowledge to all who require them. Our own studies of medical care have revealed certain local inadequacies and certain inequalities in the distribution of medical care, and we welcome the concern here shown in the endeavor to solve these problems.

If this Conference could develop a plan under medical control which would continually have the support, advice, and approval of the physicians of this country for a better distribution of physicians, so as to provide for medical care of the indigent and near-indigent people where it is found necessary under plans locally approved, State by State, it will have accomplished a great deal not only for scientific medicine but also for the preservation of the lives and liberties, and the happiness and effectiveness of our people.

It is easy to say that there are many thousands or millions living in economic conditions where health and happiness are impossible in a democracy as vast as ours. But I would like you to realize that this problem varies not only from State to State; it varies so much in the different counties or townships in each State that most formulas imposed on our people as a whole would do a great deal more harm than good.

It is with this purpose in view, and as a result of the very able address delivered by Miss Josephine Roche at the meeting of the American Public Health Association last year, that the American Medical Association has inaugurated and is pushing to completion a painstaking study of the need of medical care and the method for its provision in

*I have drawn freely not only on the *Proceedings,* but also on the pamphlet *The Nation's Health,* an abridged edition of the complete *Proceedings,* also published by the U. S. Govt. Printing Office, 1939.

each county in the United States. Hundreds of factors must be taken into consideration in each of those counties before correct diagnosis and treatment may be prescribed.

Those people who think that they can devise a centrally controlled medical service plan which can be fitted to the varying conditions of the States, counties, and cities of this country are discussing theories which no practical health administrator could possibly approve.

Dr. Hugh Cabot, of the Mayo Clinic, Vice Chairman of the Committee of Physicians for the Improvement of Medical Care, Inc.:

There has been cumulative evidence that the consumer, known to the profession as the patient, when he sees him, is beginning to wake up to the fact that he has a collateral interest in this problem, that he is the boy who is paying the bill or is going to pay the bill, and that he has a right to a very large word in what is done and in how it is done.

I am not clear (referring to the study undertaken by the American Medical Association) by precisely what method physicians are to know about the people whom they never see. The people who get no medical care obviously do not crowd the doctors' offices.

Obviously, the Government is more and more going to concern itself with the provision of medical care. I care not whether it be grants-in-aid, whether it be, as much of it must be, taken directly from taxes, or whether in certain fields it may be better dealt with by the application of the principle of insurance. The minute the Government begins to suggest the method and to provide the funds, it assumes responsibility for the product. At once it must assume a responsibility for the maintenance and improvement of standards, not only in medical care but in medical education and in research. I am afraid I shall offend somebody by saying that the maintenance of the standards of medical practice by the medical profession as at present organized has been grossly unsatisfactory. There are very large areas in this country where the practice of medicine as at present carried on is medieval.

Finally, I raise with you a question which has been on my mind for many years and I feel as if I ought to get it off. Is it possible in a highly commercialized environment to maintain a service organization on a competitive basis? If someone will answer me that one, I will be his slave for life.

Dr. William J. Kerr, President of the American College of Physicians:

It takes many years to make a good doctor—a great many years. It takes a great many years to make a fine social worker or an outstanding nurse. It is going to take us some time longer to develop the administrators and workers who are going to operate in an efficient manner any plan which may be developed. Before we are overwhelmed with a complicated system of national scope, we should undertake a program of training administrators and others who will make the system work.

Dr. Morris Fishbein, Editor of the *Journal of the American Medical Association:*

A program planned in the light of conditions in this country during the past 10 years cannot be a far-reaching program planned for a Nation which is to go forward during the next 10 years. The first problem for this Government is to relieve those conditions.

You are essentially a healthful people. Your death rates and your sickness rates compare favorably with those of any other nation in the world, regimented or unregimented, and the problem of your medical care is not the most immediate and pressing problem for the American people. Let us concern ourselves first with the question of food, fuel, clothing, shelter, and a job with adequate wages.

You must have education of your public as to the facilities already available in most of our large communities, or you will not get utilization of those facilities. We cannot promise you complete and satisfactory medical care because we don't know enough and nobody else knows enough. And when you consider the medical problem of the future, it must be considered on the basis of the knowledge of the present, not on the basis of what we hope medical research will find.

I could tear to pieces many of these data and these figures. It is not the thing to do. We are not here to tear to pieces the chart or the map which has been worked up for us for progress in this country. We are here to find out whether we can depend upon that map in charting our progress for the future; and if we cannot, then it is our business to get a map that we can depend on, based on scientific medical knowledge, based on saving all that we have and all that we have built through trial and tribulation in this country over the many years.

Dr. Borden S. Veeder, Editor of the *Journal of Pediatrics:*

In the ultimate analysis, it is the character and integrity and training of the physician upon which good medical care depends. This is the explanation, I feel, of so much of the conservatism of the medical profession that so many lay people cannot understand. Granted that adequate provision and protection for the highest type of medical service is provided in this national health program we are discussing, I am sure it will have the wholehearted support and co-operation of the majority of the physicians in the United States. I have no illusions that the problem of medical care is one that belongs purely to, and can be settled by, the medical profession alone. It is a problem that can only be solved by the co-operation of all who are concerned.

Dr. John Punnett Peters, Professor of Medicine, Yale University School of Medicine, and Secretary of the Committee of Physicians for the Improvement of Medical Care, Inc.:

The need for provision of more and better medical care has been unanimously admitted. The self-evident fact, that it can be provided for the neediest of our population only through the medium of taxation, seems also to have been accepted. At this point, it seems to me that whether the costs of providing for the partly self-sufficient are met by contributory insurance or by further taxes becomes largely a matter of accounting. Some means must be found to distribute the costs of care, for surely they cannot be neglected for this group.

Dr. Goldwater would have us go slow because the machinery of medicine is so rapidly changing. This seems to me not an entirely logical correlation. The lag between potentiality and accomplishment in the practice of medicine must be attributed to the incapacity of practitioners, despite their most ardent wishes, to keep up with science in the face of the press of an unorganized social system. The physician must have access to new facilities and new learning if he is to apply them.

Education and investigation have been mentioned too much as accessories in most of these discussions. They are the prime necessities for the success of any scheme for the improvement of medical care.

Like Dr. Veeder and all thoughtful members of the profession, I appreciate that physicians cannot alone provide an adequate system for the dispensing of medical care, but we are most aware of our particular responsibilities.

Dr. Alice Hamilton, Professor Emeritus of Harvard Medical School, and Consultant of the United States Department of Labor:

The problem as it has been laid before us here is one that will take all of the forces of the country to meet. After all, it is so largely an economic problem, isn't it? We can't ask the American Medical Association to build us rural hospitals. We certainly can't ask the ordinary practitioner to take upon himself more of the burden of medical charity than he has already assumed. In common decency we ought to take a great deal of it off his shoulders. We have asked him to do infinitely more than we have ever thought of asking the lawyers to do, although perhaps the need is just as great in connection with the lawyers.

If all of the groups of the country must help in solving this great problem, that means that the Government will have to do it. And really the Federal Government is not an invading hostile power that knows nothing about the needs of this country. It is ourselves—ourselves organized. And surely it is more or less susceptible to our influence.

William Green, President of the American Federation of Labor:

Medical service comes within the scope of national economy and hence must be paid for. The majority of persons are not wealthy, and these have the greatest number of ailments. Major sickness in the low-income family results in bankruptcy and poverty; poverty with inadequate housing and food leads to more sickness. The final result is dependence.

These families (that are self-supporting and seek to live decently and independently) constitute what are generally called the common people. They are the great productive force of the Nation, and health is essential for them in performing their work and for satisfaction in living. Frequent illness or a major illness or operation will mean bankruptcy to families with incomes between $1,000 and $3,000. Yet 57 per cent of family incomes fall between $1,000 and $3,000; 21.4 per cent are under $1,000. Obviously, the latter families can have little medical care which is not provided as a public service. Families with incomes between $1,000 and $5,000 can assume increasing degrees of responsibility as incomes rise. For these families the insurance principle of pooling risks and group organization will contribute funds to pay costs.

To accomplish our purpose, adequate medical care for all such provisions must be compulsory and under government administration.

By amending workmen's compensation laws to provide compensation for loss of time, and hospital and medical services for workers and their families during sickness, we could make substantial headway in providing better medical care for all.

Compensation for accidents and occupational diseases has been the responsibility of industry, but the extension which I propose involves different elements. Workers have a responsibility for general health and especially for their own bills for medical services for themselves and their families. Therefore, it is my opinion that workers should also contribute to such health insurance funds. Undoubtedly additional funds would be required to provide adequate service which should be supplied by Federal grants-in-aid. Such grants would strengthen State compensation laws, and would make for uniformity of provisions and better administration.

Lee Pressman, General Counsel, Congress of Industrial Organizations:

We must recognize that today we do not have adequate medical care for our people in the country. It is fairly obvious that various State governments have not taken care of this problem. It is immaterial, for our present purposes, whether the reason for such nonaction is because they didn't think it necessary to give heed to the problem or because there were a few professional groups with sufficiently strong influence in the various State legislatures to prevent adequate programs from being enacted.

With that in mind, it is difficult for me to understand why we think we will solve our problem merely by appropriating some funds through the Federal Government and giving such funds to the very organs that have heretofore refused to give heed to the problem that we are now considering. The same groups that prevented adequate programs from being enacted in the different States will still retain sufficient control to see to it that the funds that may be given by the Federal Government to those States will not be used in a manner undoubtedly desired by this Conference, or in connection with any program that we may care to recommend for enactment by Congress.

What is more, it is always difficult to try to understand what is so Biblical about those State lines that we talk about. What are the so-called diversifications in local needs? What are we talking about when we mention the different kinds of State problems, or local problems,

with regard to health? I always thought that if there was one problem which certainly did not give heed to State lines, it was the problem of the health of the people. We wonder, how can we possibly have the human genius to administer a Federal program. That kind of inferiority complex, unfortunately, is always used—too frequently used—by the reactionary forces that simply try to prevent us from having any program.

There is nothing to prevent local support, local aid, and local cooperation, even though we have Federal administration of a program. It is the feeling on the part of labor that no program for adequate health facilities can possibly succeed unless it is administered through a Federal agency.

The private agencies that have control of our health services simply cannot administer the kind of program we contemplate. It is true that the doctors of this country have sacrificed their lives, have made considerable effort to perform a public service. I do not criticize the individual doctors. I direct my attack specifically at the upper hierarchy of these medical associations that simply refuses to give adequate health service to the people of this country.

If we are determined to have a realistic program to add a new service for the people of our country, let us then not talk about getting further taxes from those very people (whom we admit have not the funds to purchase necessary medical care).

Florence Greenberg, Educational and Legislative Chairman of the Council of Auxiliaries, Steel Workers Organizing Committee:

Yesterday, Dr. West of Chicago extended an invitation to the delegates to visit the American Medical Association's offices in Chicago to see its accomplishments. I, too, want to extend an invitation to visit Chicago—but I want to show them another picture. I want to show them a sick Chicago, a Chicago of dirt and filth and tenements. The people I represent live in this part of Chicago. I speak as the representative of the organized wives of workers. My people are asking that our government take health from the list of luxuries to be bought only by money, and add it to the list of "inalienable rights" of every citizen.

When the big factories go at full power, these workers often become sick because of the dangerously bad conditions found in many plants. No wonder pneumonia is common around the steel mills when the

workers who sweat in the heat of the furnaces must rush out into the cold before they can cool off.

When "Frenchy" who works in the grinding department and in the sand blast room, starts to spit blood, his doctors find large quantities of dust in his lungs. He is too sick to work, yet he receives no compensation.

Aggie got TB from working in the "damp room" in the stockyards. She was lucky to be able to get into the sanitarium. When most Chicago workers get TB, they must try to cure it at home as best they can, because there is only one TB sanitarium for the city of 4½ million.

The Mexican family, whose little girl got double pneumonia twice, and finally died of an abscessed lung after 3 years of suffering, knows what lack of hospital facilities for the poor means. She was taken out of Michael Reese Hospital, because the relief authorities would not pay for her care any more. I attended her wake, and remember very well the hopeless look on the father's and mother's faces. They were surrounded by their other little children who were still living in the same damp basement flat in which their sister had died.

You can easily see why sickness is such a major catastrophe to a workingman's family, especially if it is the wage earner who is sick. Many sick workers are condemned to become permanent invalids, because medical services are so beyond their reach that they either do not get them at all or not until it is too late. Certainly these lifelong invalids are a much greater drain on the community than free health service would be.

Although the health status of all workers in Chicago is very poor, the health of the Negro worker is especially bad. There is six times as much tuberculosis among Negroes as among white people, and the proportion of other diseases is also very high. Still there is only one overcrowded private hospital to serve the Negro community. Life, it seems, is cheaper in Chicago than hospital beds.

Charles Taussig, President of the American Molasses Co., Chairman of the Advisory Committee, National Youth Administration:

We know a great deal more about preventing sickness than we do about preventing unemployment. Yet we courageously explore the economic field, of which we know little, and neglect the field that we have at least partially mastered.

The expenditure of $850,000,000 for public health does not frighten

business. Business bears a far greater financial burden now, due to our neglect of an adequate health control, than its share of the tax burden will be under the proposed plan. The annual toll of preventable illness measured in terms of money runs into billions. Progressive business will regard an adequate health service as a subsidy to industry, not as a burden.

We underestimate the virility of our democracy when we refuse to meet an acknowledged need, not because we do not know how to meet it, not because we lack the resources to meet it, but because we are afraid that some alien political philosophy may creep upon us unaware and destroy our institutions. If democracy in the United States has become such a feeble thing, it can no longer serve us. It is a paradox that the most vociferous vocal defenders of democracy join in proclaiming democracy's alleged inability to cope with complex social and economic problems. Let us remember that democracy is a sword as well as a shield, that its purpose is not only to defend old liberties, but to make new social and economic conquests as well.

Louis I. Dublin, Vice-President of the Metropolitan Life Insurance Company:

These are large figures and in a time of depression many agencies will raise the question of the capacity of the American people to pay such large sums. The Technical Committee properly suggests a very moderate beginning of some 10 per cent of the total and increasing that figure toward a maximum as the years pass, as competence is developed and results are obtained. But even if no such great circumspection characterized this recommendation, I should be here to urge on your courage to see this program through in its full amounts.

What is really involved? We have talked of our Nation's assets in terms of factories and lands and buildings and machinery. We have forgotten that our greatest assets are the men, women, and children. Studies which have been thoroughly confirmed show that human beings are to be valued in terms of their productive capacity at five times the value of all other national assets; and that if our total physical assets amount to some 300 billions of dollars, our human assets amount to 1,500 billions of dollars.

Over a period of some 30 years, the organization with which I am connected has spent one hundred twenty millions of dollars in health education, in the nursing of the sick, in the general prevention of dis-

ease. We, who are business men, who are used to actuarial methods, are entirely satisfied with our investment. Year in and year out we have increased our investments in the preservation of health because we felt that these investments paid. They paid in the saving of human life.

If that is true for one organization relatively small in comparison to the States and the municipalities and the Federal Government, then I say to you, do not hesitate, do not be fearful. The stakes are enormous. We have proved our capacity to achieve.

Fred K. Hoehler, Director of the American Public Welfare Association:

By and large, most of the administration of medical care and of hospital care for the needy is in the hands of public welfare officials, not by any choice of the public welfare officials, but because that is where the money was. Then, too, more significantly, I think, it is there because the public health officials of the communities would not take the responsibility, and because in the communities there was no professional leadership to assume that responsibility.

The Federal Government has, during the past several years, been putting money into States and local communities for public assistance and for W.P.A. work projects for the unemployed. That money came in without any recognition of the responsibilities for medical care, except as it came in lip service.

In considering any program for medical care or any health program, we must be concerned with the administrative framework within which it will operate, and today there is confusion and overlapping on every level of government in places where it frequently retards the progress of this program. Welfare agencies have had a larger share in shaping the responsibilities, but welfare agencies feel that they must have professional leadership.

The first step, then, in any program is to eliminate the confusion and overlapping which now exists, lest we go on with the present great gaps which have made complete service impossible. This can best be done through a national health policy and program, not to create a Utopia, but to accept minimum responsibilities, first, for those who are aided by all public assistance and relief programs, and second, for those who are otherwise medically indigent.

And finally, public welfare officials cannot and should not shirk responsibilities for administering medical care, but they are, in the large,

anxious to see this responsibility accepted by the professional health agencies in the States and in the communities, with the support of a national health program.

Mrs. H. W. Ahart, President of the Associated Women of the American Farm Bureau Federation:

Throughout the land, many a rural community has poorer medical facilities at its disposal today than it had a generation ago. Even at the peak of agricultural and national prosperity, four-fifths of the rural areas of the United States lacked any organized health service.

We carry on through our organization, in co-operation with colleges of agriculture and home economics, programs dealing with the science of nutrition, the proper development of children, better home management, education of parents, sanitation, preventive measures against diseases, and many other projects relating to the health of rural families.

More recently, our organization has boldly sponsored various phases of group medicine and health insurance, resolving to work for the enactment of laws which will make it possible for rural United States to obtain adequate medical care in terms of the ability of farmers and their families to pay for its cost.

When we brag of our machine progressiveness and of the efficiency of our industrialization, we must temper our boasts by admitting that we are 60 years behind Europe in providing health insurance for the people of the United States. Despite the opposition of the British Medical Association, Lloyd George in 1911 enacted a health insurance measure for England. A few years ago the medical men of the British Isles, by formal resolution, asked for an extension of this legislation. Today, no major European country is without some form of health insurance.

Today (here in the United States) the demand for health insurance and for adequate medical care for our entire population, both urban and rural, is a force that must be recognized, despite any objections expressed by individuals within the medical profession.

We emphasize that the ideal of group medicine or health insurance is built on co-operation between those who give aid and those who receive it. This ideal, then, properly carried out, is mutually beneficial to both groups. It is a practical ideal which appeals to common sense and common reason.

Mrs. J. K. Pettengill, President of the National Congress of Parents and Teachers:

I speak from the consumer viewpoint, representing a group of over 2 million interested individuals. I would like to say this about the matter of delay. We are awfully anxious that something shall happen soon. As parents we notice that these children grow up so fast that we are afraid that they will grow into an unhealthy adulthood before many more researches are completed.

Mrs. Saidie Orr Dunbar, of Oregon, President of the General Federation of Women's Clubs:

We still have a county in our State with only one physician; still have counties in the rural areas without hospital services or nursing services. Contrary to the statement made yesterday, there are many counties where sick people are not within 30 miles of hospital service, or 50 miles, or 75 miles. People live in those counties; children are born there, and must be reared there.

The county is the very nearest and the best understood unit of government to rural people. They know its administrators personally and naturally turn to them when needs exceed the possibility of individual solution. But the county, we must remember, has no source of income beyond land taxes, which always return the problem to the homemakers in the form of taxation. Thus we have a vicious circle. Many counties are actually bankrupt. If their books were balanced, they could no longer function.

In seeking necessary funds, it becomes more and more apparent that we must turn to outside sources, but in doing this there is one priceless thing to preserve and that is the community sense of responsibility for its own well-being and the ultimate solution of its own problems. There must be joint planning, clear-cut objectives, joint responsibility, intelligent and honest interpretation of proposed plans. There must be a place found for the participation of the lay person, be he a social worker, a public official, a member of the city club, or a community leader, and a place found in which the viewpoint of the taxpayer or the consumer, as we termed him yesterday, is to be considered.

We have members who reside in the counties where there are high maternal death rates, high infant death rates, where there are problems of malnutrition among our own school children, where there is a lack

of control of communicable disease, where there is insufficient medical and nursing care, and where there is a lack of hospitalization.

Our women of America know first-hand these things to be true. We are the mothers, and the children are our own children. We also know a very great deal about modern methods used in public health, in health services, and in health education. We ask that there be no delay in facing the health needs of our communities. In return, we offer our facilities in the determination of local health needs, in planning to meet such needs, in the support of adequate legislation and appropriations. You can count on our willingness to adhere to high standards, and to recognize the value and necessity of professional leadership thoroughly aware of the problems of life within the community.

The organized women of America will continue active support and offer you their best participation.

At this point, I wish to interrupt the quotations to emphasize an episode which was not only dramatic but important—important for what happened at the Conference and for subsequent events.

It was the first day. In the morning, Miss Roche had opened the Conference; Miss Lenroot and Dr. Parran had followed on the platform. In the afternoon, there had been seven invited speakers and then, in the general open discussion, after nine more had spoken:

The Chairman: We have time, I think, for about two more brief discussions. Mr. Kellogg.

Mr. Kellogg: Would it not bring us back on our trail of this morning were you to ask anyone here who seriously challenges the statements of need that were made in the papers this morning and were amplified this afternoon, so to state? That, it seems to me, would clarify our minds in leaving this session this afternoon.

The Chairman: That is a good closing for this session. Are there any members of this Conference who challenge the statements with reference to need which were made this morning? [Pause] There are no challenges. I assume we are agreed.

Finally, a few quotations from the closing session of the Conference.

Prof. C-E. A. Winslow, Professor of Public Health, Yale University School of Medicine:

In the discussions of one or another particular phase, we may have lost sight of the interrelationship which is so skillfully woven into it. This is not a program of health insurance, not a program for the extension of public medical service, not a program for hospital construction. It is a co-ordinated, complete, interlocking, dovetailing health program for the Nation, in which all these things have their just and proper part. To the perfecting of that program the members of this Conference have brought incalculable aid.

So far as I can recall, only one apparent criticism of the data presented has been made, and that criticism is only apparent. Father Schwitalla referred to the study that has been made by the A. M. A. indicating that only a small number of counties in the United States were in all parts more than thirty miles from a hospital. That apparently is in conflict with the figures of the Committee. But it isn't in the least, because the Committee based its judgment of hospital needs upon the number of beds available per thousand population. People use beds in hospitals, not hospitals as a whole, and the A. M. A. study simply gives you the number of people within a certain distance of a hospital. On that basis, if there were one 10-bed hospital in the city of Chicago, it would be classified as adequately cared for.

I have, as I say, discussed this thing in this room and in other rooms, but never before has it been discussed face to face with those great agencies that really represent the American people. When this health program has received, as it has received in general principle and in broad method, the support of spokesmen for both the great labor organizations of the country, of men of business, and of those who spoke for the women of the country, the parents of the country, the youth of the country, and the press—that is a fact of the most profound and momentous significance.

One problem is that of organizing the medical profession for effective service. It is not now effectively organized, for physicians are in large measure not where they are needed. It is not now organized in such a way as to give the maximum possible guarantees of quality. That last is a professional question. It is a question which must be solved by the medical profession through its medical societies, and perhaps better through its hospital staffs, and by the health officers of the community.

It is basic that the profession should be organized so as to make its services available where they are needed and to keep those services at the highest possible level of quality.

The other problem, of course, is to organize the financial resources of the community to make the maximum possible, and the maximum reasonable, payment for that professional service. It is quite clear, I think, that effective methods of organizing the community's contribution to payment can be worked out without any interference with the standards of the profession, and without any interference with the principle of freedom of choice.

I have great sympathy with the principle of freedom of choice of physician; but I should like to point out that any acceptable definition of freedom of choice of physician must include the right of a group of patients to choose a group of physicians for their service. Any artificial attempts to interfere with that freedom cannot stand.

I see in the discussion of this Conference an extraordinarily touching appeal to the medical profession. It has been its boast, and a just boast, and the source of proper pride, that if a woman came with a sick child to an individual physician and said, "My child is suffering and we want you to care for it," he never failed to respond.

What has happened here this week is that the representatives of millions of men and women in the United States have come to the medical profession as a group and said, "Our members are sick and suffering. We want medical care for them, and we want means provided by which we can pay for that service." Is it possible, is it conceivable, that that appeal is going to be rejected? I think not.

Frank Graham, President of the University of North Carolina:

And may we all congratulate the United States of America that the people through their farm organizations, their labor organizations, and women's organizations, and their consumer organizations have gathered around this Conference table to take account of this report and its meaning to scores of millions of human beings.

Another impressive thing about this Conference to me is this: That the men on the very frontier of the medical sciences are for this program. They do not take it as an attack on a great profession; they welcome it as an effort toward the fulfillment of the purposes of their great profession.

It has been good to bring the clashes we have had here out into the

daylight rather than to have had them around in the corridors after the meeting is over. When we begin to tag things and call this or that program State medicine or socialism or communism or what-not, we stop thinking and begin fighting. The test, after all, is not whether a thing is private or public, local, State, or Federal, but what according to the facts and on the merits of the case is the intelligent, the decent, and the adequate way to do a job.

There was a time when education was entirely private and sectarian. This was not adequate to the situation, and so a great public school enterprise came into being. Yet Harvard and Yale and Princeton and great numbers of other private schools and colleges still have freedom and fulfillment as needed partners to our public enterprises.

All of us can agree on one thing: that the need is great. There is need for more public health officers and for more private physicians. There is room for more private, and more public hospitals, and more voluntary associations. To meet this need the Technical Committee on Medical Care has submitted balanced, intelligent, decent proposals toward an adequate program for the health of all the people of the United States, co-ordinating the private, the voluntary, and the public interests, the individual, the county, the State, and the Federal governments, for a united advance on all shores of our mighty ocean of needs.

It is those millions of people all across this continent without adequate medical care for whom this Conference was called, and for whom the American people are determined that medical provisions must be made in our time.

These quotations may not have retained the flavor, the vigor and the sustained quality of the Conference discussions. Perhaps they have nevertheless shown—what was clear to all who were in attendance—that the people of America were there and, through their representatives from scores of organizations, showed their interest and determination in improving health services in the United States. Needs and deficiencies were presented not as a criticism of any particular group but as problems that must be met. Agreement as to the facts meant that the era of surveys was over. The time for action had arrived.

XIII

THE AMA RESOLUTIONS OF SEPTEMBER, 1938

". . . You may rest assured that in any of the efforts which you make for betterment in the health care of the people of this country, you have our wholehearted cooperation."

—Irvin Abell, M.D.,
President of the American Medical Association, speaking at the National Health Conference.

For the third time in its long history, the American Medical Association sent out a call for a Special Session of its legislative body, the House of Delegates. The session was held in Chicago, September 16-17, 1938, especially to consider the National Health Program submitted to the National Health Conference.*

After the preliminary opening addresses by various officers, the formal statement of the Board of Trustees was presented by the Chairman of the Board. In light of the actions that were taken later, it is to be noted that the Chairman gave an inaccurate account of the five recommendations of the Technical Committee on Medical Care. He said:

These proposals concern briefly (1) expansion of public health service, (2) increase of hospital facilities, (3) medical care for the medically

* Special sessions had previously been held only to deal with the problems raised by our entrance into the World War and to declare the policy of the AMA toward the work of the Committee on Economic Security in February, 1935.

indigent, (4) a general program for medical care and (5) a program for compulsory sickness insurance covering the entire population of the United States.*

A moment's reference to the original report will show that the fifth recommendation of the Technical Committee dealt with insurance against wage loss during periods of disability. The five recommendations of the Technical Committee at no point included a proposal for "a program of compulsory sickness insurance covering the entire population of the United States."

Perhaps equal significance should be given to a remark in the address of Dr. Abell, President of the Association, at the same session:

> Without calling the organized medical profession, or any considerable representation among those engaged in practice, into conference, a vast plan affecting health and medical care has been proposed to the people. In the forwarding of this plan, forces of propaganda have apparently made a studied effort to indicate that the American Medical Association opposes all change and that it is essentially a stand-pat organization.*

Dr. Abell was justified in saying that the American Medical Association had not been invited to participate in planning the government's program. Might this, by any chance, have been due to a long memory in Washington as to how the American Medical Association "co-operated" with the President's Committee on Economic Security in 1934-35? †

The "forces of propaganda" which have persuaded the American people to believe that the AMA "is essentially a stand-pat organization" are the AMA's own forces and its own propaganda. The hundreds or thousands of speeches by AMA members, the newspaper releases, the radio programs, the pontifical pronouncements and hundreds of thousands of pamphlets issued by the AMA

* Proc. of Special Session, *Journal of the American Medical Association*, September 24, 1938.

† See pp. 69-70.

have done a thorough job. They have thoroughly disabused the public mind, if it ever believed, that progressive planning or action could be expected from the AMA. And what the Association's written or spoken propaganda had incompletely done, their opposition in a hundred communities to progressive plans for medical care had finished off thoroughly. If the American people think of the AMA as a "stand-pat" organization, who but the AMA is responsible?

A complete analysis of the proceedings of the AMA'S Special Session would take us far afield. The proposals submitted by various members of the House of Delegates and by various constituent medical societies make interesting reading,* ranging over an amazing gamut of unrealistic and absurd proposals. The important points to keep in mind are that: the AMA by its opposition to progressive movements had lost its special position of medical adviser to the people of the United States; a program developed by our government had been submitted to the people and had won overwhelming support from their representatives; and the AMA was on its mettle to prove itself capable of accepting progress or even, however tardily, of showing capacity for leadership.

After two days of debate, the House of Delegates adopted (with amendments) the report of its Reference Committee—a report which is a mixture of liberalism and conservatism, of fact and fancy.

1. Under Recommendation I on Expansion of Public Health Services: (1) Your committee recommends the establishment of a federal department of health with a secretary who shall be a doctor of medicine and a member of the President's Cabinet. (2) The general principles outlined by the Technical Committee for the expansion of Public Health and Maternal and Child Health Services are approved and the American Medical Association definitely seeks to co-operate in developing efficient and economical ways and means of putting into effect this recommenda-

* The interested reader should consult the Proceedings in the *Journal of the American Medical Association*, September 24, 1938, pp. 1191-1217.

tion. (3) Any expenditures made for the expansion of public health and maternal and child health services should not include the treatment of disease except so far as this cannot be successfully accomplished through the private practitioner.

The first of these recommendations is the AMA's contribution; there was no such recommendation in the government report. The second endorses the pertinent recommendations (I-A and I-B) of the Technical Committee on Medical Care. The third says, however, that expansion of public health or of maternal and child health services must not poach on the doctor's private preserves. It leaves opportunity for endless dispute in determining when "this cannot be successfully accomplished through the private practitioner."

2. Under Recommendation II on Expansion of Hospital Facilities: Your committee favors the expansion of general hospital facilities where need exists. The hospital situation would indicate that there is at present greater need for the use of existing hospital facilities than for additional hospitals.

Your committee heartily recommends the approval of the recommendation of the technical committee stressing the use of existing hospital facilities. The stability and efficiency of many existing church and voluntary hospitals could be assured by the payment to them of the costs of the necessary hospitalization of the medically indigent.

There is nothing here with which one could take issue. The AMA endorses the Technical Committee's Recommendation II.

3. Under Recommendation III on Medical Care for the Medically Needy: Your committee advocates recognition of the principle that the complete medical care of the indigent is a responsibility of the community, medical and allied professions and that such care should be organized by local governmental units and supported by tax funds.

Since the indigent now constitute a large group in the population, your committee recognizes that the necessity for state aid for medical care may arise in poorer communities and the Federal government may need to provide funds when the state is unable to meet these emergencies.

Reports of the Bureau of the Census, of the U. S. Public Health

Service and of life insurance companies show that great progress has been made in the United States in the reduction of morbidity and mortality among all classes of people. This reflects the good quality of medical care now provided. Your committee wishes to see continued and improved the methods and practices which have brought us to this present high plane.

Your committee wishes to see established well co-ordinated programs in the various states in the nation, for improvement of food, housing and the other environmental conditions which have the greatest influence on the health of our citizens. Your committee wishes also to see established a definite and far reaching public health program for the education and information of all the people in order that they may take advantage of the present medical service available in this country.

In the face of the vanishing support of philanthropy, the medical profession as a whole will welcome the appropriation of funds to provide medical care for the medically needy, provided, first, that the public welfare administrative procedures are simplified and co-ordinated; and, second, that the provision of medical services is arranged by responsible local public officials in co-operation with the local medical profession and its allied groups.

Your committee feels that in each state a system should be developed to meet the recommendation of the National Health Conference in conformity with its suggestion that "The role of the Federal government should be principally that of giving financial and technical aid to the states in their development of sound programs through procedures largely of their own choice."

Here the AMA first accepts the principle of public responsibility for care of the indigent and that this may require not only local but also state and Federal aid. One may raise an eyebrow over the reference in the second paragraph to "these emergencies." How long must a need persist and still remain an emergency?

The third paragraph, however, goes up a blind alley. Just why does "great progress" in death rates reflect "good quality of medical care now provided"? Does not the AMA know that a high death rate may be reduced and still leave us in a disgraceful position?

The fourth and fifth paragraphs express hopes in which every-

one joins. We are all for improvement of food, housing and public health education. Then, the AMA endorses tax support to provide medical care for the medically needy. And in the last paragraph it endorses the Federal-aid proposal advanced by the government committee's Recommendation III.

4. Under Recommendation IV on a General Program of Medical Care: Your committee approves the principle of hospital service insurance which is being widely adopted throughout the country. It is susceptible of great expansion along sound lines, and your committee particularly recommends it as a community project. Experience in the operation of hospital service insurance or group hospitalization plans has demonstrated that these plans should confine themselves to provision of hospital facilities and should not include any type of medical care.

Your committee recognizes that health needs and means to supply such needs vary throughout the United States. Studies indicate that health needs are not identical in different localities but that they usually depend on local conditions and therefore are primarily local problems. Your committee therefore encourages county or district medical societies, with the approval of the state medical society of which each is a component part, to develop appropriate means to meet their local requirements.

In addition to insurance for hospitalization your committee believes it is practicable to develop cash indemnity insurance plans to cover, in whole or in part, the costs of emergency or prolonged illness. Agencies set up to provide such insurance should comply with state statutes and regulations to insure their soundness and financial responsibility and have the approval of the county and state medical societies under which they operate.

Your committee is not willing to foster any system of compulsory health insurance. Your committee is convinced that it is a complicated, bureaucratic system which has no place in a democratic state. It would undoubtedly set up a far reaching tax system with great increase in the cost of government. That it would lend itself to political control and manipulation there is no doubt.

Your committee recognizes the soundness of the principles of workmen's compensation laws and recommends the expansion of such legis-

lation to provide for meeting the costs of illness sustained as a result of employment in industry.

Your committee repeats its conviction that voluntary indemnity insurance may assist many income groups to finance their sickness costs without subsidy. Further development of group hospitalization and establishment of insurance plans on the indemnity principle to cover the cost of illness will assist in solution of these problems.

These pronouncements will bear close inspection. First, the AMA approves "hospital service insurance." Good. But to what "experience" does the AMA refer as demonstrating that these plans should not include medical care? There has been no such "experience," and it has therefore "demonstrated" nothing at all. Furthermore, local medical societies in many parts of the country have been trying for some time to work out with the group hospitalization agencies methods of extending the insurance to cover not only the hospital bill but also the doctor's bill.

Second, the AMA emphasizes local conditions, local needs and local solutions through the local medical societies. Are "health needs and means to supply such needs" exclusive problems of the medical societies? Note there is no word here about the public or its representatives, despite the fact that the problems under consideration involve people's pocketbooks as well as their health. Are these AMA pronouncements in accord with what Dr. Abell meant in the promise of "wholehearted co-operation" quoted at the head of this chapter? Or did the AMA have in mind only what he meant when he said at the National Health Conference:

> If this Conference could develop a plan *under medical control* . . . for medical care of the indigent and near-indigent people . . . it will have accomplished a great deal. . . .*

Third, the AMA endorses "cash indemnity insurance" through agencies operating under the medical societies. Inasmuch as nobody knows just what they meant by this insurance (surely not some of the crack-pot plans being circulated in some much advertised

* *Proceedings,* p. 10, italics added.

medical circles!), what can one say about it? Cash-reimbursement insurance has always been a luxury form of insurance for the middle and upper income classes. Insurance company experience has shown it to be an unavoidably expensive form of insurance. Does the AMA know some new actuarial principles on which to write an inexpensive policy worth buying? Do they mean the problem should be solved by commercial insurance? A year has elapsed since this resolution was adopted, but no plan, proposal, formula or policy has yet been made public.

Fourth, the AMA is unwilling to "foster" compulsory health insurance. That we have long known. It is "complicated"; so is medicine. It is "bureaucratic"; so is the AMA with its Bureau of this and Bureau of that. Or does "bureaucratic" merely mean something the AMA does not like, and which must be bad because the AMA gives it this name? It "has no place in a democratic state!" Page Great Britain which has had compulsory health insurance since 1911, France which has had it since 1930 or Denmark since 1933. It would increase the cost of government. But is not this offset by the 3.25 billion dollars the people of the United States now spend for medical services? And as for "political control and manipulation," does the AMA mean medical political control?

And after having delivered itself of this blast against compulsory health insurance, the AMA proceeds in the next paragraph to approve and recommend the expansion of the one form of compulsory health insurance actually practiced in the United States—workmen's compensation! For if compensation of the workman, through cash benefits and medical care, for work injuries, accidents and occupational disease is not health insurance, what is it? Is workmen's compensation "a complicated, bureaucratic system which has no place in a democratic state"? Or is it, on the contrary, social legislation to advance the protection of the worker in a democratic state through a democratic method?

5. Under Recommendation V on Insurance Against Loss of Wages During Sickness: In essence, the recommendation deals with compen-

sation of loss of wages during sickness. Your committee unreservedly endorses this principle, as it has distinct influence toward recovery and tends to reduce permanent disability. It is, however, in the interest of good medical care that the attending physician be relieved of the duty of certification of illness and of recovery, which function should be performed by a qualified medical employee of the disbursing agency.

The AMA endorses the Technical Committee's Recommendation V. But there is the reservation that the attending physician be relieved of certifying disability. It is a good guess that the AMA and the attending physicians would be the first to complain if salaried doctors of a disability insurance system undertook to examine and certify every insured worker who claimed insurance benefit.

All in all, the AMA endorsed, substantially and in principle, four of the five recommendations submitted by the Technical Committee to the National Health Conference. The AMA demonstrated it could read the handwriting on the wall and—except for its own imprisonment within the walls of criticism it had built around compulsory health insurance—it showed it could be progressive, at least to the extent of catching up to the tail of the procession.

Nevertheless, all of this was encouraging to everyone interested in national health, including the AMA and the members of its House of Delegates who adjourned with proud hearts at their accomplishment. Agreement had been reached on four points in five on a broad-gauged program; time enough to work out difference of opinion on the fifth.

But, let us not go too fast. This was September, 1938, and this was only a friendly discussion of *principles.*

XIV

THE PRESIDENT'S REPORT TO CONGRESS

"He shall from time to time give to the Congress information of the state of the Union, and recommend to their consideration such measures as he shall judge necessary and expedient; . . ."

Between September, 1938, and January, 1939, the Interdepartmental Committee to Co-ordinate Health and Welfare Activities and the Technical Committee on Medical Care continued their studies. They met with representative groups and committees from many professional and lay organizations to discuss and debate the contents of the health program—representatives of the medical professions, of farm and labor groups, of employers, of welfare administrators and of the general public. There were, among others, two meetings with the committee of physicians appointed by the House of Delegates of the American Medical Association.

I am told that almost every conceivable aspect of the subject was discussed at length with the interested groups, to explore needs, opportunities and ways and means of solving the problem, always with the understanding that the Interdepartmental Committee was prepared to give ready ear to every constructive suggestion. And, in the light of what happened to the health report of the Committee on Economic Security,* always with the understanding that the Inter-

* See p. 69.

representatives. Committee would report to the President. Finally on January 22, 1951, the Committee reported to the President, and on January 23 the President sent a special message to Congress. His message is so brief and so pointed that I include it in full.

To the Congress of the United States:

In my annual message to the Congress I referred to problems of health security. I take occasion now to bring this subject specifically to your attention in transmitting the report and recommendations of national health measures by the Interdepartmental Committee to Co-ordinate Health and Welfare Activities.

The health of the people is a public concern: ill health is a major cause of suffering, economic loss, and inefficiency; good health is essential to the security and progress of the Nation.

Health needs were studied by the Committee on Economic Security which I appointed in 1934, and certain basic steps were taken by the Congress in the Social Security Act. It was recognized at that time that a comprehensive health program was required as an essential link in our national defenses against individual and social insecurity. Further study, however, seemed necessary at that time to determine ways and means of providing this protection most effectively.

In August 1935, after the passage of the Social Security Act, I appointed the Interdepartmental Committee to Co-ordinate Health and Welfare Activities. Early in 1938, this committee turned over to the reports prepared by their technical experts. They had reviewed unmet health needs, pointed to the responsibility of a national health program, and they submitted the outlines of such a program. These reports were impressive. I therefore suggested that a conference be held to bring the findings before representatives of the general public and of the medical, public health, and allied professions.

More than 800 men and women, representing many walks of life and many parts of our country, came together in Washington late July to consider the technical committee's findings and recommendations and to offer further proposals. There was agreement on two basic points: The existence of serious unmet needs for medical services and our failure to make full application of the growing powers of medical science to prevent or control disease and disability.

I have been concerned by the evidence of inequalities that exist among the States in personnel and facilities for health services. There are

equally serious inequalities of resources, medical facilities, and services in different sections and among different economic groups. These inequalities create handicaps for the parts of our country and the groups of our people which most sorely need the benefits of modern medical science.

The objective of a national health program is to make available in all parts of our country and for all groups of our people the scientific knowledge and skill at our command to prevent and care for sickness and disability; to safeguard mothers, infants, and children; and to offset through social insurance the loss of earnings among workers who are temporarily or permanently disabled.

The committee does not propose a great expansion of Federal health services. It recommends that plans be worked out and administered by States and localities with the assistance of Federal grants-in-aid. The aim is a flexible program. The committee points out that while the eventual costs of the proposed program would be considerable, they represent a sound investment which can be expected to wipe out, in the long run, certain costs now borne in the form of relief.

We have reason to derive great satisfaction from the increase in the average length of life in our country and from the improvement in the average levels of health and well-being. Yet these improvements in the averages are cold comfort to the millions of our people whose security in health and survival is still as limited as was that of the Nation as a whole 50 years ago.

The average level of health or the average cost of sickness has little meaning for those who now must meet personal catastrophes. To know that a stream is 4 feet deep on the average is of little help to those who drown in the places where it is 10 feet deep. The recommendations of the committee offer a program to bridge that stream by reducing the risks of needless suffering and death, and of costs and dependency, that now overwhelm millions of individual families and sap the resources of the Nation.

I recommend the report of the interdepartmental committee for careful study by the Congress. The essence of the program recommended by the Committee is Federal-State co-operation. Federal legislation necessarily precedes, for it indicates the assistance which may be made available to the States in a co-operative program for the Nation's health.

FRANKLIN D. ROOSEVELT

The White House,
January 23, 1939

This brief message, less than a thousand words, from the President is clear and incisive.

"The health of the people is a public concern; . . .

"Health needs were studied . . .

"I have been concerned by the evidence of inequalities that exist among the states . . .

"The objective of a national health program is to make available in all parts of our country and for all groups of our people . . .

"We have reason to derive great satisfaction from the increase in the average length of life . . .

"The average level of health or the average cost of sickness has little meaning for those who now must meet personal catastrophes.

"I recommend the report of the interdepartmental committee for careful study by the Congress."

Accompanying the President's message was not only the Report of the Technical Committee which has already been reviewed, but also a special report by the Interdepartmental Committee in which it summarized its position in the following brief passage:

> The committee believes, in brief, that it is both possible and necessary to embark on a long-range plan to put science to work so that, within the limits of present knowledge and potential resources, all of the American people will have the greatest possible opportunity to live out their lives in health and vigor, free to the maximum possible degree from the unhappiness and the economic burdens that result from sickness, disability, and premature death.

The Interdepartmental Committee reviewed the need for a national health program, outlined the scope of such a program, pointed to the opportunities to maintain and advance the quality of medical care and summarized the experience of the National Health Conference. Then it submitted its own recommendations which are substantially identical with those presented by the Technical Committee to the Conference, with one major exception. The third and fourth recommendations of the Technical Committee (III. Medical care for needy and medically needy people; IV. General programs

of medical care) are combined into one recommendation, so that the Interdepartmental Committee's recommendations are only four in number. These four recommendations, including the text of the new combined recommendation, read as follows:

A. The committee recommends the expansion and strengthening of existing Federal-State co-operative health programs under the Social Security Act through more nearly adequate grants-in-aid to the States and, through the States, to the localities.

B. The committee recommends grants-in-aid to the States for the construction, enlargement, and modernization of hospitals and related facilities where these are nonexistent or inadequate but are needed, including the construction of health and diagnostic centers in areas, especially rural or sparsely populated, inaccessible to hospitals. The committee also recommends grants toward operating costs during the first years of such newly developed institutions to assist the States and localities in taking over responsibilities.

C. The committee recommends that the Federal Government provide grants-in-aid to the States to assist them in developing programs of medical care.

A state program of medical care should take account of the needs of all persons for whom medical services are now inadequate. Attention has often been focused on those for whom local, state, or Federal responsibility through the public-assistance provisions of the Social Security Act and through work relief or general relief, and upon those who, though able to purchase food, shelter, and clothing, are unable to pay for necessary medical care. The committee's studies show, however, that attention should more properly be focused on the needs of the entire population or, at least, on the needs of all low-income groups. Medical services are now inadequate among self-supporting people with small incomes as well as among needy and medically needy persons.

The committee believes that choice of the groups to be served, the scope of the services furnished, and the methods used to finance the program should be made by the States, subject to conformity of State plans with standards necessary to insure effective use of the Federal grants-in-aid.

To finance the program, two sources of funds could be drawn upon by the States: (a) General taxation or special tax assessments, and (b) specific insurance contributions from the potential beneficiaries of an

insurance system. The committee recommends grants-in-aid to States which develop programs using either method, or a combination of the two, to implement programs of medical care.

The committee believes it is of fundamental importance that a medical-care program developed by a State should be a unified program applicable to all groups to be served. It would be unsound to have one system of medical care for a relief population and another for self-supporting groups. A unified program might be developed through tax support for public medical services for all included groups; or through an insurance system financed by contributions, including contributions from public funds on behalf of persons in need; or through other arrangements.

D. The committee recommends the development of social insurance to insure partial replacement of wages during temporary or permanent disability.

The effect of Recommendation C is to make emphatically clear the interrelations of medical services among all groups in the population. Moreover, this recommendation goes further, if possible, than the Technical Committee had gone in leaving the broadest possible latitudes to the states in deciding what kind of program, if any, they may choose to develop. Whether the Committee took this position in response to pressures from the American Medical Association and other groups or to clarify its own position, we do not know. Several members of the Interdepartmental Committee are known to be administrators who place great emphasis on the strength and democratic stability of Federal-state co-operative programs and this may have had much to do with the Committee's decision. In any event, this amendment of the original recommendations deprived the critics of the last shred of reason for shouting "federalization," or "centralization." Of course, the shout will go up; those who enjoy this kind of noise are little concerned with reason. The recommendations are themselves the best reply to critics who oppose all progress with arguments of super-patriotism. Indeed, if the recommendations are to be criticized on reasonable grounds, it is because of their emphasis on state, instead of Federal, programs and operations.

Directly after the President's message was received by the Congress, Senator Robert F. Wagner of New York announced that he was preparing a bill to put the national health program before Congress for legislative action.

XV

SENATOR WAGNER'S NATIONAL HEALTH BILL

PREAMBLE

"To provide for the general welfare by enabling the several States to make more adequate provision for public health, prevention and control of disease, maternal and child health services, construction and maintenance of needed hospitals and health centers, care of the sick, disability insurance, and training of personnel; to amend the Social Security Act; and for other purposes."

On February 28, 1939, the senior Senator from New York, Robert F. Wagner, introduced a bill to modernize the health services of the United States. The bill became "S. 1620" and was referred to the Committee on Education and Labor of the Senate.

Senator Wagner is, of course, well known as the sponsor of many of the most important pieces of social legislation enacted in recent years by the Congress of the United States. His name is associated with the Wagner-Peyser Act which developed the public employment offices throughout the country, the National Labor Relations Act, the Federal Employment Stabilization Act, the Slum Clearance Act, the Federal Housing Act of 1938 which laid down the fundamentals of the housing program, with the first Unemployment Insurance Bill, 1933, and with the original Economic Security Bill, which he first introduced in 1934 and out of which came the Social Security Act of 1935.

Senator Wagner came to the United States Senate with a long

record of having sponsored and supported legislation in the New York State Legislature to improve working and living conditions of industrial workers. In New York his basic legislation for improving conditions in factories and workshops and for broad social legislation, growing out of the work of the Factory Investigating Commission of which he was Chairman, his sponsorship of the workmen's compensation law, of the public health reorganization law, and of many other progressive developments won him great public recognition. In 1938, he was Democratic leader in the New York State Constitutional Convention and it was largely under his leadership that the Convention acted favorably on the constitutional amendment authorizing the enactment of health insurance by the State Legislature. This social insurance amendment received the largest public endorsement of any of the nine amendments submitted to the voters of the state.

Even in the face of powerful and insidious opposition, it is not surprising that he was unafraid to undertake the difficult work of sponsoring legislation for national health. Nor is it surprising that he chose to develop health legislation by building on the Social Security Act which, with all its imperfections, has shown through four years of practical experience that it is a soundly conceived law of the land. The insurance provisions of the Act were declared constitutional by the United States Supreme Court in May, 1937; the other parts of the Act, providing grants-in-aid to the states, have not been challenged. In 1938, Senator Wagner introduced a resolution calling for an investigation of the health needs of the United States, but this resolution died in committee. In 1939, he returned to the task to which he had set his hand.

By way of introduction to the Wagner health bill, it is well to have in mind the broad outlines of the Social Security Act which is amended by this bill. That Act consists of eleven parts, called titles, which best can be reviewed by disregarding their actual sequence in the law.

Title I authorizes grants-in-aid to the states for old-age assistance,

pensions to needy aged persons; Title IV authorizes similar grants to states for aid to dependent children; and Title X authorizes similar grants for the needy blind. These three, Titles I, IV and X, are the "public assistance" titles.

Title II sets up a system of old-age benefits for persons sixty-five years of age and older who have worked in industrial and commercial employments specified in the law; Title VIII levies taxes on employers and employees in these specified employments. These two, taken together, make up our Federal system of old-age insurance under which annuities become payable "as a right" to all who have contributed "premiums" through the taxes levied in Title VIII.

Title III authorizes grants to states for the administration of unemployment insurance if the state systems meet certain conditions specified in the law; Title IX levies taxes on employers in certain employments specified in the law and allows employers credits, up to 90 per cent of these taxes, for taxes paid under approved state systems of unemployment compensation. These two titles, taken together, are the basis for unemployment compensation, "job insurance," in all states.

Title VII creates the Social Security Board and specifies its duties. Titles I, II, III, IV and X (and part of IX dealing with certification of state unemployment insurance laws) are administered by the Board; Titles VIII and IX (collection of taxes) are administered by the Treasury Department.

Title V authorizes grants for maternal and child health services (Part 1), services for crippled children (Part 2) and for child-welfare services (Part 3)—all administered by the Children's Bureau of the Department of Labor. It also authorizes grants for vocational rehabilitation (Part 4), administered by the Office of Education in the Department of the Interior.*

Title VI authorizes grants to the states for public health services

* The Office of Education and the Public Health Service—as well as the Social Security Board and a number of others—have been transferred by the President under the authority of the Reorganization Act and are now all in the newly created Federal Security Agency.

and for the investigation of disease and problems of sanitation, administered by the United States Public Health Service in the Treasury Department.*

Title XI contains general provisions such as definitions, authority to make necessary administrative rules and regulations.

Although the Social Security Act is a complex law, its parts are essential elements in a program to bring economic and social security to the people of this country. The law is complex because the problem is complex. In addition to old-age insurance, job insurance, and aid to the needy aged, children and blind, it made a beginning toward the development of health protection for mothers, infants and children, and for the strengthening of preventive health services. It was, therefore, logical for Senator Wagner to build on this framework when he undertook the strengthening of the nation's protection against sickness and disability through S. 1620 which he designated as the "National Health Act of 1939."

The health bill seems formidable when one turns its forty-seven pages. Yet it is so simply written that one need not be a lawyer to understand it. Some parts of the bill require a knowledge of orderly governmental procedure; some sections require at least elementary economic knowledge; and all of it—to be appreciated—requires eyes with which to see the unmet health needs of the country, eyes undimmed by the prejudice and propaganda that have been circulating the length and breadth of the land.

S. 1620 amends two Titles (V and VI) of the Social Security Act, adds three new Titles (XII, XIII and XIV) and amends some sections of the present Title XI (general provisions). What the bill proposes to do may be grasped by comparing its provisions with the recommendations of the Interdepartmental Committee transmitted to Congress by the President.

RECOMMENDATION A: The committee recommends the ex-

* The Office of Education and the Public Health Service—as well as the Social Security Board and a number of others—have been transferred by the President under the authority of the Reorganization Act and are now all in the newly created Federal Security Agency.

pansion and strengthening of existing Federal-state co-operative health programs under the Social Security Act through more nearly adequate grants-in-aid to the states and, through the states, to the localities.

S. 1620: The present Social Security Act, including the amendments made in August, 1939, authorizes the following appropriations for Title V:

Part 1, Maternal and child health services	$5,820,000
Part 2, Services for crippled children	3,870,000

1. THE WAGNER BILL AMENDS THESE FIGURES TO THE FOLLOWING:

	1939-1940	1940-1941	1941-1942
Part 1	$8,000,000	$20,000,000	$35,000,000
Part 2	13,000,000	25,000,000	35,000,000

All of these sums are to be allotted and granted to the states. The program, now operating under the Social Security Act, continues to be a Federal-state co-operative undertaking. Through the states, the funds and the services they would support go to the localities as at present.

The Social Security Act now authorizes the appropriation of $11,000,000 for grants to the states for public health services. The Wagner bill amends this figure to become:

1939-1940	1940-1941	1941-1942
$15,000,000	$25,000,000	$60,000,000

For the years subsequent to the fiscal year ending June 30, 1942, the bill authorizes in each case the appropriation of "a sum sufficient to carry out the purposes of this title." This has been seized on by some naive critics of the bill, who have charged that this phrase harbors some sinister purpose, making unlimited appropriations. Such critics reveal an abysmal ignorance of legislative language and practice. In the first place, this language is customary and common; for example, it is found in Titles I, IV and X of the present Social Security Act. In the second place, they seem to be unaware that an

authorization is merely a declaration of policy; it is not an *appropriation*. After an appropriation is authorized, the funds must be justified each year before the appropriation committees of the House of Representatives and of the Senate, and must be appropriated *each year by both houses of Congress* and must be approved by the President. This is the regular practice of Congress.

RECOMMENDATION B: The committee recommends grants-in-aid to the states for the construction, enlargement, and modernization of hospitals and related facilities where these are non-existent or inadequate but are needed, including the construction of health and diagnostic centers in areas, especially rural or sparsely populated, inaccessible to hospitals. The committee also recommends grants toward operating costs during the first years of such newly developed institutions to assist the states and localities in taking over responsibilities.

S. 1620: The Wagner bill proposes a new Title XII, authorizing "Grants to States for Hospitals and Health Centers." Its provisions may be related to the Committee recommendation point by point:

> For the purpose of enabling each State, . . . especially in rural areas and in areas suffering from severe economic distress, to construct and improve needed hospitals, to assist the States for a period of three years in defraying the operating cost of added facilities. . . . (Section 1201) The term "hospital" . . . includes health, diagnostic, and treatment centers, institutions, and related facilities. (Section 1209)

For the construction of general hospitals, S. 1620 authorizes only $8,000,000 for the first year, $50,000,000 for the second, and $100,000,000 for the third. For mental and tuberculosis hospitals, it authorizes as much as may be necessary. It will be recalled that the Technical Committee found deficiencies of general hospitals which they estimated would cost $630,000,000 to build; and deficiencies of $475,000,000 in mental and tuberculosis institutions. Our existing hospitals represent a capital investment of about three billion dollars.

For temporary maintenance grants "to assist the States and locali-

ties in taking over responsibilities" of newly developed institutions, S. 1620 provides for the payment of $300 per added bed in general and tuberculosis hospitals, and $150 per bed in mental hospitals, during the first year of operation; two-thirds of these amounts for the second year; one-third for the third year; and none thereafter.

RECOMMENDATION C: The committee recommends that the Federal government provide grants-in-aid to the States to assist them in developing programs of medical care.

S. 1620: The Wagner bill proposes a new Title XIII, authorizing "Grants to States for Medical Care."

> For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas and among individuals suffering from severe economic distress, to extend and improve medical care. . . . (Section 1301)

Nothing in the Title requires a state to do anything unless it chooses to do so. Nothing in the Title limits a state as to the groups of people it may undertake to aid, as to the kinds of service (general practitioner, specialist, hospital service, etc.) it may wish to provide, or as to the use of public medical services, health insurance or any other method of providing service.

The bill authorizes the appropriation of the modest sum of $35,000,000 for grants-in-aid to states during the fiscal year 1939-1940, and thereafter a sum sufficient to carry out the purposes of the title.

RECOMMENDATION D: The committee recommends the development of social insurance to insure partial replacement of wages during temporary or permanent disability.

S. 1620: The Wagner bill proposes to meet part of this recommendation through Title XIV, "Grants to States for Temporary Disability Compensation." There is authorized for the fiscal year 1939-1940 the sum of $10,000,000 and thereafter a sufficient sum to carry out the purposes of the Title. The money is to be paid to the states which establish state systems of temporary disability compensation that meet specified standards. The Federal grant is to be one-

third of the amounts spent by the states for wage-loss benefits and for administration.

There is no provision in the Wagner bill for social insurance against *permanent* disability; Title XIV is restricted to *temporary* disability. In this respect S. 1620 fails to carry out part of the Committee's recommendation. However, the reason is not far to find. The Committee proposed that annuities for permanently disabled workers should be closely related to old-age insurance annuities, because most persons who become permanently disabled are close to retirement age, and their annuities should be reasonably related to retirement annuities and should be furnished through the Federal system of old-age insurance. At the time Senator Wagner introduced his bill, a program for permanent disability annuities recommended by the Social Security Board was already before Congress and was being considered by the Ways and Means Committee of the House of Representatives. It may therefore be assumed that Senator Wagner did not consider it was necessary or advisable to include an overlapping proposal in his health bill.

The Ways and Means Committee did not make provision for permanent disability benefits in its amendment of the old-age insurance system, although it did provide for annuities for the wives, dependent children and widows of insured workers. This Committee's bill was passed by the House of Representatives on June 10, 1939, and sent to the Senate. On June 15, while the Senate Committee on Finance was holding hearings on the House bill (H.R. 6635), Senator Wagner introduced amendments to provide annuities for insured workers who become permanently and totally disabled. These amendments were not adopted by the Finance Committee. There are no benefits for permanently disabled workers in the bill finally passed by Congress on August 4-5, 1939.

Each Title of S. 1620 specifies in carefully defined language the conditions which a state must meet in order to receive grant-in-aid from the Federal government. Such conditions are obviously neces-

sary to make sure that the sums granted to a state will be expended, with reasonable efficiency, for the purposes for which the money is appropriated by Congress. Such conditions always accompany a grant-in-aid appropriation. The expenditures, however, are to be made by the states and localities, not by the Federal government.

The conditions of approval of state plans vary somewhat from Title to Title in the Wagner bill. This is necessary because the conditions must be adjusted to the nature of the program. Some requirements are, however, common to various Titles. For example, it is uniformly required that the state programs shall: be administered by a single state agency; provide for a state-wide program or for extension within five years to all parts of the state in need of the services; provide for efficient methods of administration, including a merit basis for the administrative personnel, that is, civil service to avoid political appointments; provide for co-operation among various state agencies administering closely related services.

In order that the Federal agency which approves or disapproves the state plans shall not have excessive or arbitrary power, each Title has an explicit protection. In every case, it is specified in the bill that the Federal agency—whether this is the Children's Bureau, the Public Health Service or the Social Security Board—*shall approve* any state plan which meets the conditions specified as prerequisites for approval. While there must be a Federal agency to certify that a state is entitled to Federal aid, that Federal agency cannot use arbitrary power in making a decision. The very same conditions which assure that a state will spend the Federal government's money for the intended purposes, simultaneously guarantee that the state will receive the money from the Federal government if entitled to the grant.

The National Health Program proposed that Federal grants-in-aid should be adjusted to the financial needs of the states. Generally, those which are poorest have the greatest amount of sickness, their people need most service and they have the least money with which

to buy and pay for the services. Federal grants should therefore be adjusted to the financial needs of the states.

The health bill meets this objective by a system of variable grants. In Titles V, VI, XII and XIII, it is provided that Federal payments to the states shall be adjusted according to the financial resources of the states. In Section 1101-e, an amendment to Title XI, the bill provides that the financial resources of the states shall be measured by their per capita incomes, as determined jointly by the Secretary of the Treasury, the Secretary of Labor and the Chairman of the Social Security Board. These government officers are required to arrange the states according to per capita income. The state with the lowest per capita income shall be assigned a "matching proportion" of 66⅔ per cent; the state with the highest income shall be assigned 33⅓ per cent. Thus, the poorest state would get two-thirds of the cost of its health program from the Federal government; the richest state would get one-third; and intermediate states would get intermediate proportions. These "matching proportions," running from two-thirds to one-third, apply to Titles V, VI and XII. For Title XIII, the bill requires that the variable grants shall range from a maximum of one-half to a minimum of one-sixth. Some doubt may be expressed whether it would be altogether practicable to have different matching proportions apply to the same state for closely related parts of a health program.

It must be evident from this analysis that Senator Wagner has carried out his announced intention to put the National Health Program into shape for practical consideration. More particularly, it must be apparent from even so brief an analysis of his bill—and surely it will be evident to anyone who studies the bill in detail—that he has carried out his difficult task in the statesmanlike manner the country has come to expect of him.

Finally, it must be evident that not only the Interdepartmental Committee but Senator Wagner as well has shown commendable restraint and wisdom in designing a program adjusted to the rea-

sonable demands of the American Medical Association and its constituent societies. The reader who will re-examine the principles embodied in the Interdepartmental Committee's report and in the Wagner bill, in light of the resolutions adopted by the American Medical Association in September, 1938, will find there are no real conflicts. The AMA approved in principle four of the five recommendations submitted by the Technical Committee on Medical Care. The AMA disapproved compulsory health insurance. *There is no compulsory health insurance in the Wagner bill.* The bill leaves to each state the decision on how to provide medical care, and how much, to its citizens.

XVI

PUBLIC HEARINGS ON THE WAGNER NATIONAL HEALTH BILL

Public hearings provide an opportunity for those actively interested to express an opinion on proposed legislation. What is said in public hearings is often a fair cross-section of the opinions given by interested groups and individuals to members of the legislature; at other times it is evident that the really influential forces are working through private and "off-the-record" discussions. In the case of S.1620, the National Health Bill, there is every reason to believe that the public hearings give a fair picture of opinion on the bill. Representatives of public, professional and institutional groups most directly interested have stated their views for the public record. The record shows, and it is the testimony of people who attended all of the hearings, that the public sessions were conducted with every courtesy and every effort to give a fair hearing to each witness.*

The hearings on S.1620 were not consecutive because the members of the committee were also holding hearings on other pro-

* The complete record of the hearings has been published: To Establish a National Health Program, Hearings before a Subcommittee of the Committee on Education and Labor, U. S. Senate. 76th Congress, 1st Session, on S. 1620. 3 Parts. Govt. Printing Office, Washington, D. C., 1939.

posed legislation. The health bill hearings were conducted by a sub-committee of the Senate Committee on Education and Labor. The members of this sub-committee are: Senator Murray (Montana, Chairman, and Senators Donahey (Ohio), Ellender (Louisiana), LaFollette (Wisconsin) and Taft (Ohio).

A preliminary session was held on April 27, 1939, to permit representatives of various agricultural groups who were in Washington on other business to testify. Subsequent hearings were held on May 4 and 5, May 11 and 12, and were then broken off for two weeks because the American Medical Association was about to hold its annual meetings in St. Louis (May 15-19), where it planned to consider the health bill before coming before the Senate committee to testify. Hearings were resumed on May 25 and 26, and were terminated on July 13, 1939. The gist of the hearings can be summarized as follows:

1. Representatives of agriculture, labor, civic, welfare and other public groups endorsed the bill and its objectives. There were many who suggested amendments but these were constructive criticisms. Among these witnesses were representatives from the American Farm Bureau Federation, the Associated Women of that organization, the National Farmers Union, the General Federation of Women's Clubs, the American Public Welfare Association, the American Youth Congress, the American Association for Social Security, the American Federation of Labor (AF of L), the Congress of Industrial Organizations (CIO), the National Women's Trade Union League, the American Association for Labor Legislation, the National Association for the Advancement of Colored People, the National Negro Congress, the Bureau of Co-operative Medicine, the National Conference of Catholic Charities.

2. Representatives of public health, nursing, and independent medical and specialist professional groups endorsed the bill or those parts of special concern to them. Again, there were constructive criticisms. In this group may be included representatives from the American Public Health Association, the Conference of State and

Provincial Health Authorities of North America, the Committee of Physicians for the Improvement of Medical Care,* the National Tuberculosis Association, the American Academy of Pediatrics, the National Medical Association.

3. Representatives of "organized medicine" (the AMA and its constituent state societies) opposed the bill altogether and offered no suggestions for its improvement. Representatives of various dental and hospital associations took positions which ranged all the way from the AMA stand to endorsement of some objectives and opposition to others, with and without constructive suggestions.

4. Representatives of Federal agencies, charged under the bill with administrative responsibilities, endorsed the reasonableness of the bill's provisions and assured the Senate committee that the bill provides a practical basis for action. Miss Katharine Lenroot, Chief, and Dr. Martha M. Eliot, Assistant-Chief of the Children's Bureau, Dr. Thomas Parran, Surgeon General of the Public Health Service, and Mr. Arthur J. Altmeyer, Chairman of the Social Security Board, suggested amendments to improve the bill. Their testimony further strengthened the evidence of need for Federal health legislation and showed the practicability of S.1620.

As far as the support of the bill is concerned, it need not delay us here; it was substantially the same as that which had been expressed at the National Health Conference in July, 1938. As for the opposition, that is worth analysis because it tells us better than anything else the problems that are ahead in making modern health services more generally available to the people of the United States. I want, therefore, to review this testimony and comment upon it.

If, in what follows, the reader is inclined at any point to think I am severe in my comments, I invite him to keep in mind not only the resolutions adopted by the AMA in September, 1938, when its Special Session of the House of Delegates endorsed most of the report of the Technical Committee, but also the assurances of

* See p. 72.

co-operation given at the National Health Conference by the President of the AMA. Dr. Abell said to the Conference:

> The officials of the American Medical Association come to this meeting at the express instructions of its House of Delegates. We come not imbued with a controversial spirit, but with a determination to give to this Conference our best thought, our experience, and the information which has been accumulated in our bureaus through the years that have passed since the organization of the American Medical Association.
>
> The heads of our technical departments are here, carrying with them the information which we have in our files and which we gladly place at the disposal of this Conference. You may rest assured that in any of the efforts which you make for betterment in the health care of the people of this country, you have our wholehearted co-operation. We shall be most glad and most happy to give our services, to be of help to you in that respect.*

The participation of the AMA in the public hearings on the Wagner bill began on May 5, 1939. On that day, Dr. Arthur W. Booth, Chairman of the Board of Trustees of the AMA, stated that he appeared not in a personal but in a representative capacity, "to state the position of the American Medical Association with respect to some of the proposals set forth in the pending bill, S.1620, . . ." He pointed out that the AMA had had no meeting since the bill was introduced, but would consider the bill at the annual meetings scheduled to begin May 15 and would be prepared to present its views on the bill after those meetings; the House of Delegates had, however, considered the Technical Committee's report in September and, judged by the principles laid down at that time, "S.1620, as a whole and in many of its details, is unsound, and its enactment would not be in the public interest."

The reasons for his position?

* These passages are quoted from the *Proceedings* of the National Health Conference, p. 65. It is significant that Dr. Abell was not among those who testified for the AMA against the health bill.

What follows is based upon his prepared statement issued to the press and his answers to the questions from the Senators:

1. The AMA resolved in favor of a constructive program to provide people with food, shelter, etc., and there is nothing to this effect in the Wagner health bill;

2. The bill had its origin in Washington;

3. The benefits of the bill are open to every state, rich and poor alike;

4. Federal subsidy might invade intra-state matters—*but* [later he said] the AMA is not opposed to Federal aid to the states;

5. The AMA recommended the creation of a Department of Health with a doctor as a cabinet officer at the head, and S.1620 does not do this;

6. S.1620 does not adequately protect the interests of private practitioners against the use of public funds for the treatment of disease;

7. S.1620 does not provide adequate protection against the construction of hospitals, health centers, etc., that are not really needed;

8. S.1620 does not limit its medical-care program exclusively to the indigent;

9. S.1620 "paves the way" for compulsory health insurance;

10. The AMA was not consulted in the framing of the bill;

11. The bill proposes too much centralization of power in Washington—*but* [he also said] a Secretary of Health should have the right to give money to some states and withhold it from others;

12. The bill proposes the creation of advisory councils and you cannot tell what their composition would be—*but* these councils would be all right if the medical societies could appoint the members;

13. Health matters should be decided in the states and localities, not in Washington—*but* [he also said] the people of New York State did not know what is best for them when they voted overwhelmingly to amend their state constitution to authorize their legislature to enact health insurance when it deems such legislation wise;

14. The AMA is "fostering" voluntary health insurance but is opposed to compulsory health insurance;

15. The bill follows the spirit of the September resolutions of the AMA but bungles the administrative provisions—*but* [later he said] the administration would be all right if there were a Secretary of Health—a doctor—who would have broad powers, and if the AMA had influence over, and control of, the administrator;

16. The standards written into the bill to control Federal allotment of money to states is "technical verbiage"; and

17. *Dr. Booth had not read through the bill.*

These points speak for themselves. If anyone thinks this is in any way an unfair summary of the AMA position as expressed by the Chairman of the Board of Trustees, I urge the reader to examine the testimony for himself.*

Between the preliminary testimony of Dr. Booth on May 5 and the subsequent testimony of the other representatives of the AMA on May 25, the Association held its annual meetings and declared its position on the bill. It summarized its objections in twenty-two points, presented by Dr. Walter Donaldson, Secretary of the Pennsylvania State Medical Society, Pittsburgh, Pennsylvania, on behalf of the House of Delegates of the AMA. I include the twenty-two points in full because they serve, better than anything I could write, to show the problem involved in obtaining leadership or assistance from the AMA in the development of our national health services:

1. The Wagner Health Bill does not recognize either the spirit or the

* The following is the comment on Dr. Booth's testimony in a medical periodical: "A hearing before the Senate Committee on the Wagner Bill has been in progress and the pros and cons were being heard. The representative of the AMA—the president of the board of trustees—who was given the assignment of supporting the position of the AMA and the medical profession before the Senate Committee, was compelled to admit that he had not read the bill. In consequence, such arguments as he had to present were nullified.

"Comments upon this turn of events naturally assumes various forms. There is no accounting for a bonehead performance." *Weekly Roster and Medical Digest* (Philadelphia), June 3, 1939, p. 1285.

text of the resolutions adopted by the House of Delegates of the American Medical Association in September 1938.

2. The House of Delegates cannot approve the methods by which the objectives of the National Health Program are to be obtained.

3. The Wagner Health Bill does not safeguard in any way the continued existence of the private practitioners who have always brought to the people the benefits of scientific research and treatment.

4. The Wagner Health Bill does not provide for the use of the thousands of vacant beds now available in hundreds of church and community general hospitals.

5. The Bill proposes to make Federal aid for medical care the rule rather than the exception.

6. The Wagner Health Bill does not recognize the need for suitable food, sanitary housing and the improvement of other environmental conditions necessary to the continuous prevention of disease.

7. The Wagner Health Bill insidiously promotes the development of a complete system of tax supported governmental medical care.

8. While the Wagner Health Bill provides compensation for loss of wages during illness, it also proposes to provide complete medical service in addition to such compensation.

9. The Wagner Health Bill provides for supreme Federal control; Federal agents are given authority to disapprove plans proposed by the individual states.

10. The Wagner Health Bill prescribes no method for determining the nature and extent of the needs for preventive and other medical services for which it proposes allotments of funds.

11. The Wagner Health Bill is inconsistent with the fundamental principles of medical care established by scientific medical experience and is therefore contrary to the best interests of the American people.

12. The fortunate health conditions which prevail in the United States cannot be dissociated from the prevailing standards and methods of medical practice.

13. No other profession and no other group have done more for the improvement of public health, the prevention of disease and the care of the sick than have the medical profession and the American Medical Association.

14. The American Medical Association would fail in its public trust if it neglected to express itself unmistakably and emphatically regarding any threat to the national health and well-being. It must, therefore,

speaking with professional competence, oppose the Wagner Health Bill.

15. The House of Delegates would urge the development of a mechanism for meeting the needs for expansion of preventive medical services, extension of medical care for the indigent and the medically indigent, with local determination of needs and local control of administration, within the philosophy of the American form of government and without damage to the quality of medical service.

16. The fundamental question is how and when a state should be given financial aid by the Federal government out of the resources of the states as a whole, pooled in the Federal Treasury.

17. The bizarre thinking which evolved the system of Federal subsidies—sometimes called "grants-in-aid"—is used to induce states to carry on activities suggested frequently in the first instance by officers and employees of the Federal government.

18. The use of Federal subsidies to accomplish such federally determined activities has invariably involved Federal control.

19. Any state in actual need for the prevention of disease, the promotion of health and the care of the sick should be able to obtain such aid in a medical emergency without stimulating every other state to seek and to accept similar aid, and thus to have imposed on it the burden of Federal control.

20. The mechanism by which this end is to be accomplished, whether through a Federal agency to which any state in need of Federal financial assistance can apply, or through a new agency created for this purpose or through responsible officers of existing Federal agencies, must be developed by the Executive and the Congress, who are charged with these duties.

21. Such a method would afford to every state an agency to which it might apply for Federal assistance without involving every other state in the Union or the entire government in the transaction.

22. Such a method would not disturb permanently the American concept of democratic government.

Some of these twenty-two points (for example, 1, 3, 4, 7, 8, 9, 10 and 15) must seem absurd to anyone who has actually read the bill; some of the points are merely expressions of general opinion with which nobody would quarrel or to which only the AMA could subscribe; and some express a philosophy as to the place of medicine in modern society that requires no comment.

It is recorded that the AMA report on the bill was adopted by the House of Delegates "without dissent." However, I have been told that the opposing votes were not even called for by the chairman. It is therefore significant that some members of the House of Delegates * appeared later to testify in favor of the objectives of those Titles of the bill on which they are experts. Unanimous resolutions by the House of Delegates, even when they are sharply reversing previously adopted policies, is one of those things that happen in "well regulated" organizations.

When the public hearings were resumed on May 25, the American Medical Association appeared with a large delegation of witnesses. On the whole, they had a well-planned campaign of procedure, but on one or two occasions they nearly came to grief. One witness or another was nearly caught, in the cross-examination, and was on the point of offering a constructive amendment to meet the objections he had cited against the bill. Once when a witness started to say that he would be in favor of the bill, or of a bill, that met his specific criticisms, he was saved, by what a newspaper writer called "coaching from the side-lines," by the Chairman of their Legislative Committee who presided as master of ceremonies. Otherwise, the testimony was a lengthy repetition of the twenty-two points and the alleged reasons for the adoption of these points. It was evident in the cross-examination that the witnesses were merely presenting what was in their prepared statements. One suspects that the twenty-two points were merely a "front," and that the AMA was not altogether frank in presenting its real reasons for opposition to the bill.

Here and there, in nearly two hundred pages of AMA testimony, some witnesses made sound criticisms. The Senators showed they welcomed helpful suggestions. But at nearly every point, the Senators' questions were met with the reply that some other witness

* See, for example, the testimony of Dr. A. C. McCormack of Kentucky and of Dr. Felix Underwood of Mississippi, from which excerpts are quoted in the Preliminary Report on the bill to the Senate. Also, see the endorsement of the bill by Dr. J. N. Baker of Alabama in the *Journal of the AMA*, April 22, 1939.

would explain what the prepared statements meant or how a proposal could be met. Sometimes the answer was that the present bill could not be made acceptable, no matter how amended, not even (or only) if it were completely rewritten. The AMA wanted no Federal legislation.

Two or three episodes in the testimony are selected for special comment. I know that it is dangerous to select passages from testimony; it may be charged that the selections give an unfair picture of the whole. The interested reader may judge for himself by reading the original testimony.

During the annual meetings in St. Louis, the AMA publicity made much ado over the results of their own study on unmet medical needs in the United States. Dr. Braasch, Chairman of the AMA study committee, reported that only about forty thousand people might be without medical care, instead of the forty million whom the Technical Committee on Medical Care had said, on the basis of the National Health Survey, are without medical care or receive inadequate care. This is a wide gap—between forty thousand and forty million! And the press of the country was given this information to show how unreliable are the statistics developed by government officers. Let us see what developed on this point at the hearings on the health bill.

Dr. R. G. Leland, Director of the Bureau of Medical Economics, the bureau that has been conducting their study and preparing the statistical analysis, was on the witness stand for the AMA. He was asked whether he endorsed the opinion that only about forty thousand people are without adequate medical care. He declined to say, on the ground that the study was still incomplete and the analysis of the data not yet finished. Dr. Braasch had had no such compunctions at the AMA convention. There is more than a suspicion, however, that both the statistics and the report used by Dr. Braasch had been prepared in Dr. Leland's Bureau. Finally, under questioning from Senator Taft, Dr. Leland stated that the

forty thousand to which Dr. Braasch's report referred were people "who were *denied*" medical care! This is quite a different matter from the number who obtain inadequate medical care or none at all. Yet this was used to cast a shadow on the official government reports.

Dr. Leland: . . . The statement that was made was to the effect that the figure would be more likely to be 40,000 than 40,000,000 who are denied medical care, meaning the people who sought medical care and who had been turned away or refused medical services. There is quite a difference.

Senator Taft: It is very different from the number who might have lack of means and not be in touch with a hospital.

Dr. Leland: Very different.

Senator Taft: So really there is no comparison whatsoever between the 40,000,000 and the 40,000.

Dr. Leland: No comparison at all.

Senator Murray: And there are a great many people, of course, who are unable to pay for medical care themselves. . . .

Dr. Leland: That is right.

Yet Dr. Braasch's report had been used to influence the deliberations of the House of Delegates in St. Louis and had been featured in releases to the nation's press.

Dr. Haven Emerson, Professor of Public Health Administration, Columbia University, was known for many years as a progressive liberal among public health workers. In recent years he has been an outspoken critic of the New Deal and has been associated more and more with conservative groups. He has been prominent among those who have criticized the report of the government's Technical Committee on Medical Care. On May 25, he appeared for the AMA as a witness. He said many things with which I should take issue; but I want only to call attention to the extraordinary contrast between the position he took at these hearings and the conclusions he reached a few years ago when he was studying medical eco-

nomics as a member of the Committee on the Costs of Medical Care.

The AMA has stated over and over again that it is not opposed to health insurance but is opposed to *compulsory* health insurance. Dr. Emerson, appearing on behalf of the AMA, supported their position.

Dr. Emerson was for five years a member of the Committee on the Costs of Medical Care † and throughout that period he was a member of its Executive Committee which was responsible for close supervision and criticism of the research studies. This Committee submitted as the third recommendation in its Final Report (November, 1932) the following:

> Recommendation 3.—The Committee recommends that the costs of medical care be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both of these methods. . . ." (Final Report, p. 120.)

In the text discussing this recommendation, the Committee said:

> The majority of the Committee, although aware of the limitations of coverage and the possible difficulties of voluntary health insurance, nevertheless believe that the ultimate results will be far better if experience with actuarial and administrative details, and above all the evolution of group practice units capable of rendering rounded medical service of high quality, precede the adoption of any compulsory plan by a state as a whole.* (Final Report, p. 127.)

The asterisk in this quotation refers to a footnote which is a reservation signed by Dr. Emerson and four others (all of whom signed the majority report of the Committee) recording their opinion in this footnote that the Committee should not go on record as favoring voluntary insurance in preference to compusory insurance. This footnote actually terminates as follows:

> Therefore, we feel that the report should not emphasize or recommend voluntary health insurance over required health insurance, or vice versa,

† See Chapter V.

but that both plans or a combination of the two be equally recommended by the Committee for experimentation. (Final Report, p. 128.)

That was Dr. Emerson's opinion when he was studying the question. But that was in 1932 before action was impending. Politics makes strange bedfellows.

There were some ludicrous statements made by AMA witnesses in cross-examination at the hearings. For example, Dr. Sensenich, a member of the Board of Trustees of the AMA, criticized clinics; he seemed unaware that one of the chief purposes of Title XIII of the bill is to help make use of empty hospital beds by providing money with which to pay for hospital care; he interpreted the temporary maintenance grant of $300 a year per bed in new hospitals as paying the *whole* cost of hospitalization (it would pay about one-third or less); he showed he did not know that the U. S. Public Health Service has had experience in operating hospitals (the Service has been operating hospitals for over one hundred years and that is still its largest function); he did not know where to find a definition of "hospital" except in the dictionary (the AMA has been maintaining a hospital register for many years). The testimony of Dr. Charles Gordon Heyd needs to be read in the original to be fully appreciated. One point that was developed in the cross-examination of Dr. Heyd is so important that I am reserving it for the following chapter to be treated by itself.

The AMA testimony was capped by Dr. Morris Fishbein whose vaporings on the subject are so well publicized that they need no review here.

What does it all add up to? Despite previous resolutions and previous assurances of co-operation and that their services are at the disposal of government, the AMA came to Washington and said in effect to the United States Senate: We do not like this bill. It is bad; it is full of bad provisions. You didn't ask us to help you write the bill and so we can't help you rewrite it. We

do not want Federal health legislation; health isn't the business of the Federal government. And if it were, a good bill would put us in control of health administration.

I think this means that the AMA will, as long as possible, fight against any new legislation to extend and improve health services. When they find that it is the will of the people of the United States to have Federal health legislation, the AMA will try to gain control and manage things to suit itself.

XVII

THE GANNETT COMMITTEE UPHOLDS THE CONSTITUTION

The American Medical Association has always been in politics, but until very recently it has been only in "medical politics." From its beginnings, the AMA has identified the interest of the individual doctor with the public interest, and it has played a powerful and effective hand in Federal, state and local legislation.

The Bureau of Legal Medicine and Legislation, one of the permanent bureaus of the AMA, serves as a central watchdog of all legislation and legislative proposals affecting medicine. It "cooperates" with state and local medical societies in keeping them advised and informed of their interest and "interests." Anyone who has had any experience in such matters knows that the medical "lobby" is well organized for effective expression of medical opinions in the towns, cities, counties and states of the country and in the nation's capital. Anyone interested in the operation of such lobbying has only to read the annual reports of the officers of the AMA, which are published each year in the *Journal of the American Medical Association* shortly before the annual meetings, or has only to examine the annual reports of state or local medical societies. The reports of officers, committees and "public relations" counselors make interesting study.

To the extent that this is professional and not partisan politics and to the extent that the professional interest coincides with the public interest, such lobbying is clearly part of our democratic process. And to the extent that such lobbying has worked to prevent the passage of "crackpot" legislation, it has undoubtedly been in the public interest. Smooth-functioning medical lobbies bring their influence to bear when other groups advance proposals that would unwisely relax the laws that safeguard licensure or that would permit unqualified persons, quacks or charlatans, to practice medicine or surgery, or that would allow advertising to defraud the public and endanger the public health.

So far so good, though it is often a nice question just when the public interest coincides with the interest of individual doctors, especially when economic questions are involved or when a medical society opposes public health legislation on the ground that expansion of public service would "invade" the preserves of the private practitioner.

Those who are not acquainted with the political activity of medical societies and those who think of them merely as professional associations for the advancement of science, may receive a shock from some of the methods used. A typical procedure is illustrated by the following quotation (a hundred similar examples could be readily compiled) taken from the first page of a weekly published by the Philadelphia Medical Society; I have chosen this example only because it deals with the Wagner health bill and because it is simple, straightforward and unusually temperate.

Now if you are convinced, after reading it, that the Wagner Bill is not advantageous to public welfare, which should be your principal concern, write to U. S. Senator James J. Davis and U. S. Senator Joseph F. Guffey at the Senate Office Building in Washington, D. C., and see or write your Congressmen AT ONCE expressing your reasons why it is not in public interest.*

* *Weekly Roster and Medical Digest,* the Official Bulletin of the Medical Organization of Philadelphia and Vicinity. Published weekly by the Philadelphia County Medical Society, June 3, 1939, p. 1285.

Such political activities presumably explain, in part or in whole, why many medical societies are classified as "business leagues" rather than as scientific societies, and are not exempt from taxation. There are some medical societies which do not engage in such activities and these are widely respected as strictly non-profit professional organizations devoted to scientific purposes.

It is still more of a shock and surprise when medical associations start to organize what has recently been called a "sickroom lobby." At the last annual meeting of the House of Delegates of the AMA (May 18, 1939), the President-Elect, Dr. Nathan B. Van Etten, advised physicians to organize an intensive propaganda campaign against the Wagner bill. Every doctor should undertake "to educate his patients. . . . Every delegate must realize his official obligation as never before and carry home to every single practitioner in his state a full consciousness of the importance of this declaration of principles. That practitioner is potentially one of the most powerful persons in the democracy. If he can be made to see his duty to his country and educate his patients to a realization of the dangers of centralized control of medical practice, your action of yesterday will be sustained." *

This is only one step further than medical societies have already gone when they have used similar methods before, or when they have supplied their members with specially prepared leaflets to be left in a conspicuous place in the doctors' waiting rooms, or when (as in one case which is of record) a state medical society used society funds to pay a special writer for one or more magazine articles attacking "socialized medicine." All of this is, of course, old stuff. And when I see a newspaper headline "Head of AMA Warns Doctors of Propaganda," † I cannot help wondering whether the headline writer had his tongue in his cheek.

Such political activities, however, are fair game. It is a game played not only by frankly political organizations, but also by

* *Journal of the American Medical Association*, June 3, 1939, p. 2298.
† New York *Herald Tribune*, June 7, 1939.

trade and business associations of employers, by labor unions and by many kinds of "business leagues" that look out for their own interests. It is not really news. But when the AMA leaders get mixed up in partisan politics, that is news. Let us look at the record.

Mr. Frank Gannett and his "National Committee to Uphold Constitutional Government" are well known to the American public for their anti-New Deal activities. They have been issuing a magazine called *America's Future,* which spreads itself on many anti-New Deal fronts.

Beginning with the New Year issue of 1939, medicine and "socialized medicine" became one of their active interests. The leading article in this issue, "Do You Want Your Own Doctor or a Job Holder?" appears over the name of Chas. Gordon Heyd, M.D., there identified as Past-President, American Medical Association. Early in March, directly after Senator Wagner introduced his health bill, the Gannett Committee sent out a form letter, signed by Frank Gannett, criticizing the bill, expressing sympathy with the AMA—"Their fight is our fight to preserve free enterprise"—advising the addressee to write letters of protest to his Senators and to give financial support to the Committee. This letter must have been sent broadcast; I am told it was even sent to Senator Wagner's office in New York!

This letter was followed (in New York) by a circular letter to physicians, on the letterhead of the Gannett Committee, advising of a recent meeting by a group of physicians "on invitation as private citizens" to hear a discussion of the trend toward state medicine! A campaign is to be started, it says. This was followed by a telegram saying that "Today's mail brings you from Sumner Gerard a booklet 'Political Medicine and You.' . . . Will you read and give support measured by importance of issue or if already supporting interest others." This telegram was signed: "Charles Gordon Heyd Past-President American Medical Association John A. Hartwell Past-President Academy of Medicine NY." (At the

hearings on the Wagner bill Dr. Heyd testified he had signed the telegram but he had not "the remotest idea" to how many people it had been sent because he had authorized the Gannett Committee to send it out on their mailing lists.)

The physicians attending the meeting called by Gannett, or some of them, organized the "Physicians Committee for Free Enterprise in Medicine" whose letterhead says: "Work with the National Committee to Uphold Constitutional Government, Frank Gannett, Chairman, Sumner Gerard, Treasurer." It has sent out letters to physicians of the country organizing a political campaign against the Wagner bill and inviting membership and subscriptions. It is interesting to note that this letterhead includes the following among the members of the "Temporary National Organization Committee:

Dr. Roy W. Fouts, Vice-Speaker of the AMA House of Delegates

Dr. Roger I. Lee
Dr. Chas. B. Wright
} On the AMA Board of Trustees

Dr. Robert L. Benson
Dr. E. H. Cary
Dr. Chas. Gordon Heyd
Dr. Wingate M. Johnson
Dr. J. Milton Robb
Dr. Walter E. Vest
} Members of the official delegation testifying for the AMA on the Wagner bill before the Senate sub-committee.

Adding Dr. Heyd and Dr. Haven Emerson, who are listed on the letterhead as members of the "Organization Committee" for New York, the letterhead accounts for all but two members of the AMA testifying committee, exclusive of the salaried AMA officers. Dr. Van Etten, the AMA President-Elect, is also among those named on the letterhead.

There is nothing on the letterhead or in the letter that *directly* connects the "Physicians Committee . . ." or the Gannett Committee with the AMA; but is it merely accident or chance that

all but two of the non-salaried, official spokesmen for the AMA are sponsors of the campaign? To be sure the actions of these physicians in their individual capacities are not binding on the AMA. But there are at least two obvious connecting links: (1) the dual connections of the individuals; and (2) Dr. Heyd's use of the title "Past-President American Medical Association" on his article in *America's Future* and in the telegram that got the campaign under way. If Dr. Heyd had been using his connection with the AMA unethically or in such a way as to embarrass the AMA, there has been no outward sign; Dr. Heyd was *subsequently* among those who appeared officially to testify on behalf of the AMA before the Senate sub-committee.

And as for the "National Committee to Uphold Constitutional Government," a letter originally published in the *New York Medical Week,* introduced in the Senate hearings when Dr. Heyd was testifying, points out that the man who is (or was) manager of this "patriotic" committee was once convicted and sentenced for trading with the enemy during the World War! The letter adds:

> One cannot escape the suspicion that a committee to uphold the Constitution which needs the services of a former spy smacks of that patriotism which is the last refuge of a scoundrel.
>
> The fact that outstanding men in the profession have joined the Gannett Committee puts the whole profession in a very questionable light before the lay public. The opinions of these men are not representative of the profession as a whole, as was shown at the meeting of the Kings County Medical Society (reported in the *New York Times,* April 23, 1939), when a resolution condemning the Free Enterprise group was passed by a vote of ten to one. . . .*

I think most people will agree with me that unofficially, if not officially, the AMA which has hitherto avoided partisan politics is playing a dangerous game. Is it willing to use even partisan politics to defeat health legislation? How much do the salaried officers of the AMA know about this tie-up with the Gannett Committee?

* The *New York Medical Week,* Official Organ of the Medical Society of the County of New York, May 6, 1939, pp. 10-11.

XVIII

A PRELIMINARY REPORT TO THE U. S. SENATE: AUGUST, 1939

"The Committee on Education and Labor, to whom was referred the bill (S. 1620) . . . appointed a subcommittee to consider the bill.

"This subcommittee, having studied this bill, held numerous public hearings and accumulated a large volume of testimony and supplementary information, reports that it is in agreement with the general purposes and objectives of this bill. However, the subcommittee wishes to give this legislation additional study and to consult further with representatives of lay organizations and of the professions concerned. The subcommittee intends to report out an amended bill at the next session of Congress."

—Report No. 1139, U. S. Senate (76th Congress, 1st Session); August 4, 1939.

With these words, Senator James E. Murray opens the preliminary report to the Senate from the subcommittee which has been in charge of the National Health Bill.

Some who had hoped the bill might be enacted this year (1939) may be disappointed; but their disappointment is probably not so acute as that of the opponents who have been confident the bill would "die in committee." The committee's report, a document of forty-two pages, shows that the legislation is being considered with care and discernment. The committee endorses the purposes and objectives of the bill and serves notice in the concluding paragraph that "the committee will continue its study of S. 1620 so that a definitive report on the proposed legislation can be submitted soon

after the beginning of the next session of the Congress." It is, therefore, of the utmost importance that all who are concerned with the nation's health services and with social and economic aspects of these services should give careful thought to the plans that must be worked out in the near future.

I do not intend to review the Senate committee's report at length; I wish only to examine a few of the larger problems to which the committee directs attention. The report reviews: (I) the need for a national health program, chiefly in terms of the testimony given at the hearings, presenting the background of the bill, the opportunities for improvement of health in the United States, the causes of inadequate health services, the need for disability insurance and the need for Federal action. It then considers: (II) the principles underlying the bill; (III) its principal provisions; (IV) some special problems raised in the hearings; and (V) the special problems of industrial health and safety hazards.

The Senate committee report points out that the Wagner health bill is the logical outgrowth of several years of preparatory study and discussion, and that it proposes a necessary and desirable rounding out of the social security program. It recognizes that the opportunities for improvement of health in the United States are enormous and the methods of dealing with many existing problems are at hand. Among the causes of inadequate health services, the committee cites, from the testimony presented at its hearings, the historical, the organizational and the financial reasons which I have reviewed in earlier chapters. The burdens of sickness costs emphasized by representatives of labor, agriculture, civic and welfare groups require remedies which only the Federal government can initiate.

The Senate committee shows repeatedly that it is conscious and highly appreciative of the great contributions made by voluntary organizations—professional, charitable, church, fraternal, civic and so forth—but it recognizes that the health problems of today call for efforts which only our entire society can make through the

considered action of government. The committee concludes that existing circumstances, and the outlook for the future, are such that action by the Federal government is imperative; and the "primary opportunity for the Federal Government is to give financial and technical aid to the States."

Among the principles underlying the National Health Bill, the committee first stresses the basic pattern—action through Federal-state co-operative programs. The report quotes at some length testimony showing that health programs of this pattern now in operation have been and are working successfully, without dictation of the state programs by the Federal agencies. The testimony of state health officers agrees with that of Federal administrators that the health programs are operated and controlled by the states, not by the Federal government.

The Senate committee emphasizes that in grant-in-aid legislation each state is given assurance its plans will be approved and the state will be entitled to receive grants-in-aid if they conform to requirements specified in the law. The committee also emphasizes the new opportunities afforded by the bill to improve the quality of medical care.

The provision of variable grants-in-aid, in preference to fixed matching on a fifty-fifty ratio or some other uniform proportion, receives special notice. The subject of variable-matching grants in connection with Federal assistance was given extended consideration at the last session of Congress because of the proposals to use this type of allotment for the needy aged, dependent children and the blind. Amendment of the Social Security Act to replace fixed matching by variable matching had been recommended by the Social Security Board, but this policy was not adopted by Congress. The Senate committee points out it does not seem to be generally known that variable-matching grants have always been in the health Titles (V and VI) of the Social Security Act. Experience and available evidence show that variable Federal grants, with the proportions based on the financial resources of the states, are sound and

necessary for the further development of health services. The formulas for the measurement of state financial resources and for the determination of variable matching proportions present complex problems and studies on these points are still in progress.

The Wagner health bill deals with insurance against temporary, but not against permanent, disability. Insurance against permanent disability was under consideration during 1939 by another Senate committee which was studying amendment of the old-age insurance provisions in the Social Security Act. The committee report implies that because no action was taken by the other committee, permanent disability insurance will be carefully considered when the study of temporary disability insurance, under Title XIV, is resumed in 1940.

As to the amounts of money and the rate of development contemplated by the health bill, the committee has reached no final decision. "These are questions which require much further study."

These and similar subjects discussed in the Senate report are important; but they have already been treated in preceding chapters and need not delay us here. It is more important to give some attention to the special problems raised in the hearings and singled out by the committee for special notice. Some of these I shall comment on only briefly; a few deserve particular attention.

Some witnesses, representing the American Medical Association, criticized the bill because it would provide Federal aid for medical education and research. On the other hand, a number of progressive physicians criticized it because the provision for the "training of personnel" seems to apply only to administrative personnel and because there are no provisions for education and research. Obviously, these criticisms cannot both be sound.

The need for financial support to strengthen professional education and research is increasing, because the costs are rising and philanthropic subsidies are becoming inadequate. Substantial support would involve large sums of money, and the committee may hesitate to propose that the Federal government should enter this

field on a large scale. The government is already making small grants for the postgraduate training of specialists in public health, venereal disease and cancer work, and is already making modest research grants-in-aid through the U. S. Public Health Service. It seems as if a sound program could be developed by explicitly providing that grants-in-aid proposed under various titles should be available for education and research as well as for the other purposes specified in the bill. Several witnesses recommended that Federal aid should be available for health education of the public. This could be handled in the same way as the preceding one.

The interests of minority population groups in state health programs receive special comment. Negroes are fearful that their health needs would not receive adequate attention, especially "in States where separate health facilities are maintained for separate races." The Wagner bill already places so much emphasis on the health needs of groups "suffering from severe economic distress," that the intent of the bill to meet the needs of Negroes and other underprivileged groups seems to be clear.

Negro physicians, dentists, nurses and pharmacists are fearful they will continue to be discriminated against in the opportunities to furnish tax-supported services for needy members of their own race. There can be no doubt that, in a number of states, their fears are well grounded. The problem of protecting Negro practitioners is, unfortunately, complicated by medico-political maneuvers.

It is widely known behind the scenes that Negro physicians and dentists are very anxious to win from the American Medical Association assurances of equality in admission to membership in local medical societies, and the deletion of the designation "col." after the names of Negroes in the AMA national directory of physicians. Resolutions to these general effects, introduced before the House of Delegates of the AMA at their annual meetings in May, 1939, on the initiative of delegates from the New York state society, were passed over with promises of further consultation by the AMA

and representative Negro physicians. Although a spokesman for the National Medical Association (Negro) endorsed the broad objectives of the Wagner health bill before the Senate committee, some Negro physicians have been trying to drive a bargain with the AMA—in effect offering opposition to the bill in return for an AMA concession as to membership in the societies and unqualified listing in the AMA directory. Are these individuals prepared to sacrifice what the national health program offers for millions of Negroes in return for promised advantages to some Negro practitioners? Such political bargaining is unfortunate and short-sighted. The Senate committee announces it "believes that there should be just and equitable allocation of funds according to the needs for services, and will study carefully the amendments suggested to carry out these purposes."

Various witnesses who appeared at the committee's hearings urged that the bill be amended to specify that state plans shall be required to include particular classes of services or to assure the right of various types of practitioners to serve under the plans. It seems to me that the committee wisely hesitates or declines to accept these recommendations. As long as the bill follows a Federal-state co-operative pattern, the scope of service should be left flexible for the states to decide. Nor should the Federal government intervene in deciding who may or may not practice the healing arts. This has been, and should properly remain, a state function. It is sound that the Federal administrators should have authority to lay down at least minimum standards that must be met in a state plan qualifying for Federal aid; but Federal authority should not dictate to a state that cultists of one kind or another shall be eligible to furnish services under a state plan, aided by Federal funds. If anything were written into the bill on this subject, it should be designed to work in the opposite direction; Federal money should not pay for the services of substandard practitioners or institutions. Federal legislation should operate to raise, not to lower, the quality standards of medical care.

There has apparently been some confusion over the provision that state plans qualifying for Federal aid should use and encourage co-operative arrangements with practitioner and welfare groups and organizations. The Senate committee reports there is no difference of opinion as to the intent of the legislation to encourage such arrangements, and the language of the bill will be clarified on this point.

Industrial hygiene services need to be greatly strengthened, and the subject receives considerable attention in the committee report. There has been difference of opinion over the methods which should be used in the states. Some think industrial hygiene activity should be encouraged by the Federal government only as a function of state health departments; others think that the activities of both health and labor departments should be assisted by Federal grants-in-aid.

It seems to me that concentration of these activities in a single state agency, the health department, is *theoretically* desirable. The fact is, however, that health departments have been only mildly interested in the subject, have had only casual interest in the responsibility of enforcing health and safety standards in factories and workshops and commonly have been given limited, if any, enforcement powers by the state legislatures. Labor departments—which have also been relatively inactive in many states—are usually little interested in basic health studies but, in many states, have the right of entry into working places and the authority and the duty of establishing and enforcing health and safety standards.

The Senate committee reports it is considering carefully a compromise proposal, in the form of an additional Title (XV) to the bill. Under this Title, appropriations to the U. S. Department of Labor would provide grants-in-aid to the states

> to assist them in extending and improving their activities in the control of working conditions and practices involving health and safety hazards in industrial establishments, in the development and enforcement of

pertinent regulations, and in assisting them in the administration of workmen's compensation laws.

A state plan would have to provide for administration by the state labor department, or for supervision by this department of any part of the plan administered by another agency. The industrial hygiene activities of state health departments would be limited so as not to overlap those authorized for labor departments under the proposed Title. It is intended that—as far as Federal aid is concerned—the development of industrial hygiene knowledge and skill, studies on occupational disease and general health services for workers would remain within the scope of health department activities; the study and control of health hazards due to working conditions and practices in industrial establishments, the establishment and enforcement of regulations and the strengthening of workmen's compensation would be within the scope of labor departments. This seems to be a reasonable and practical compromise solution.

The income limit of the population to be served by state plans under the health program receives brief but pointed attention from the committee. The bill places emphasis on the needs of rural areas and on areas or individuals suffering from severe economic distress; otherwise it leaves to the states decisions as to the population groups to be furnished services. Those, like the AMA, who want the program restricted to the needy would like to see the states limited in the potential breadth of their plans. Such amendment of the bill would not only restrain the states, but would deprive tens of millions of wage earners, agricultural laborers, farmers, salaried workers and self-employed persons of the benefits of the program. It would strike a death blow at the efforts to bring better and more medical care to low income families who receive little or no care, and to those who now struggle under the burdens of sickness costs. Other witnesses have, on the contrary, urged an amendment that would require the states to meet explicit health

insurance specifications, with wide coverage, as a condition for the receipt of Federal aid.

With such conflicting recommendations before them, the Senate committee said it believed that the present, flexible formula of the bill is sound; it leaves wide latitude to the states in deciding whom to cover in their plans.

The committee considers the administrative provisions of the bill at some length. The AMA and some others have urged that there should be only a single administrative agency, a Federal Department of Health. I have already pointed out that this seems to be part of a move for the AMA to get a doctor at the head of all Federal health agencies so that the AMA can have control. The criticism that the bill sets up three Federal administrative agencies (the Children's Bureau, the Public Health Service and the Social Security Board) is already largely met; the Public Health Service and the Social Security Board are now parts of the newly-created Federal Security Agency and are as much one as though they were within a single Department. There remains the problem of co-ordination with the Children's Bureau, which is still in the Department of Labor. Appropriate co-ordination will, presumably, be worked out; or it may be that the health functions of the Children's Bureau are slated for transfer to the Federal Security Agency.

When dealing with these administrative matters, the committee remarks that some witnesses have recommended that Title XIII (general medical care) should be administered by the Public Health Service instead of by the Social Security Board. This raises a fundamental question. There can be no doubt that the Public Health Service has had long and successful experience in some kinds of medical service and in operating hospitals, and the Board has not. Is this a determining reason for assignment of administrative responsibility?

The transfer of Title XIII is just what the AMA would like. The proposal must, therefore, be viewed with the greatest suspicion. The Public Health Service has been accustomed to deal,

does deal and would continue to deal with the state health departments. These are undoubtedly the state agencies which would and should develop public health, and maternal and child health programs. Are these, however, the agencies in the states from which we can expect medical care developments? I doubt it very much. In some states, the health departments are even legally under the control of the state medical societies, and in many other states they are completely dominated by these societies without legal sanction. What can one expect in the way of leadership from the state health departments toward solving the medical care problems of wage earners, farmers, agricultural laborers, salaried workers, or small business men and their families? Many state health commissioners tremble at the name of health insurance and avoid responsibilities for medical care because of possible difficulties with the medical societies. Also the leadership of the Public Health Service has been, in the recent past, either definitely opposed to health insurance or cautious on questions involving expansion of medical services. This is understandable since many of its public health duties require close collaboration with the AMA and with the state and local medical societies, as well as with the state and local health departments.

Against all this, the Social Security Board has a fine record for courageous leadership and skillful administration; it works closely and effectively with the welfare agencies of the states—the agencies which are not dominated by the medical societies and which have gone ahead with provision of medical services; and it is the one organization in the Federal government which knows the problems and the administrative techniques of social insurance. No special professional group could control, in its own interest, the policies of the Social Security Board. If the Board needs professional experts and advice, it could get all this from the Public Health Service or from professional employees or advisers. Medical care for the poor must be correlated with the provision of sub-

sistence grants for these people, and all of this is the field of the Social Security Board.

I do not know the reasons which led Senator Wagner to assign Title XIII to the Social Security Board in his bill as first introduced; but whatever those reasons were, the assignment which he worked out still seems fundamentally sound.

Finally, I wish to comment on two special points bearing on hospital questions. Representatives of the voluntary hospitals (charitable, church and others) have expressed great alarm about Title XII (construction of hospitals). They fear that Federal aid for the construction of hospitals, health or diagnostic centers, and related facilities will lead to the building of such institutions even in places where they are not needed, and that such new institutions will compete with or displace existing non-governmental institutions. It is quite obvious that such is not the intention of the bill. The Senate committee therefore gives assurances it "intends to prepare amendments to Title XII to assure that Federal aid under this Title will require unequivocally clear showing of need through impartial State and local surveys, and clear satisfaction of Federal requirements that such needs exist, in addition to reasonable demonstration as to future continuing support of the hospitals." It is to be hoped, however, that in carrying out these worthy intentions the committee will not lean so far backwards as to set up requirements that will unnecessarily delay the building of needed hospitals, health centers, diagnostic laboratories and related facilities.

The representatives of non-governmental hospitals have also shown great alarm because there is no explicit statement in the bill that their hospitals shall be eligible for use under state plans financed in part by Federal aid. There is nothing in the bill to prohibit any state from using such hospitals as are qualified to furnish services covered by a state plan. The intention of Title XIII (general medical care) is clearly to assist states in making more effective use of qualified hospitals that are only partly used because people in need of hospital service cannot pay the costs. Sena-

tor Wagner has repeatedly stated this intention. The Senate committee makes this point very strongly, but concludes that "in order that all doubts and fears on this score may be resolved, the committee is agreed that the bill should be amended by addition of positive provisions that qualified hospitals and agencies, both public and private, may be utilized in the State plans."

The committee report is a notable document. Its review of the facts and issues, of the proposed legislation and of the problems, is masterly. It shows a clear understanding of the job to be done and of the highly technical obstacles that must be surmounted if the legislation is to be sound and workable.

While Senator Murray's committee and Senator Wagner are deliberating further on S. 1620, it is to be hoped they are keeping in mind our experience with social insurance administration. Federal old-age insurance is operating more successfully than state unemployment compensation. Does this experience hold a lesson for the health and disability programs?

XIX

THE ROAD AHEAD

The time will surely come when we shall have adequate health services for all of our citizens, rich and poor, on the farms and in the cities. Medical service will, like education, be assured to every citizen as a birthright in a democracy which treasures physical and mental health as an essential for the pursuit of happiness. The profession of medicine will be freed from the limitations of the business of medicine and will have enlarged opportunities for service. It will be stimulated by the same humane and scientific motives which actuate all men and women devoted to the advancement of knowledge and skill.

The profit motive is not essential in the practice of medicine. This is evident in thousands of communities where physicians serve their fellow citizens without any hope of large financial reward; it is evident in many of our finest medical schools and research laboratories where an annual salary is not a reward but a means of achieving freedom to give single-minded service in a humane cause.

This is a distant goal, and many and slow are the steps to be taken. In a final sense, the pace will be set by public need and demand; it may be accelerated or retarded by individuals or incidents; but the steady and relentless pressure of social necessity will, in the long run, determine the rate of advance. Public conviction develops at a slow pace, but when it comes, action is not far behind.

I have reviewed at length the National Health Program and the National Health Bill, not because either is a perfect instrument or gives the final answer to our national health needs, but because it seems to me that these are long steps on the road ahead.

This bill provides the funds with which the Federal government and the states can now begin to march forward. The combination of public health, public medical service and social insurance proposed by the National Health Bill of 1939 is sound and constructive; it gives great hope of progress.

It is inevitable that all who labor in this cause will be tagged with slogans and labels that stir emotions. One has only to recall the phrase "socialism and communism—inciting to revolution" applied by the Editor of the AMA's *Journal* to the conservative report of the Committee on the Costs of Medical Care, of which Dr. Ray Lyman Wilbur was Chairman.

As I write these words, I have before me clippings from a newspaper published in New York state in which a full-page spread, issued by local medical societies once a week, shows that the campaign to identify health insurance with Communism has already begun. I am reminded of an editorial which appeared a few years ago in one of the leading British medical journals. Commenting on this sort of propaganda, it said that some American physicians seem unable to distinguish between "sociology" and "socialism."

Though bitterness and reaction have slowed down, they cannot permanently block, progress. It is a hopeful sign that AMA officers used to obstruct all proposals for progress; now they talk only of slowing down developments in order to protect the public against intemperate haste. Intemperate haste, indeed! Must we see another suffering generation pass before we develop the health services that we know how to furnish today?

There are some who would develop public medical care through expansion of existing public health practices, service by service. This method leads to chaos. It was sound a generation or more ago when we were taking our first steps in the conquest of tuberculosis and

in the care of the insane. It had its merits in the campaign against diphtheria which brought this disease under control and was a vehicle for health education of the public. The method is useful in the present war against syphilis—a war in which the walls of prudery and social prejudice must be razed so that we may control this devastating disease.

This endless multiplying of special campaigns, special organizations and special arrangements to deal with individual diseases, has served its purpose and should cease.

Professional judgment considers unity of preventive and curative care essential for modern health service. If we are to preserve or recapture that unity, if we are to give people simple and ready access to necessary service, we must solve the organizational and economic problems of medicine on a broad front. Otherwise the complexity of the parts will destroy the usefulness of the whole.

The preliminary report from Senator Murray's committee to the United States Senate encourages us to hope that a beginning will soon be made on the national front. Each state, under the Wagner Health Bill, is free to determine the organization and financial plan best suited to its needs—whether this be health insurance, tax-support or a combination of the two. Each state may decide. We must therefore begin to direct attention to the problems of organizing health services in the states and local areas. It is there a health program must operate; it is there it will have its real successes and failures; it is there it will bring health services for families and individuals.

One of the tragedies of today is that many states and localities lack the courageous leadership found among officers of the Federal government. Fortunately, the enactment of national health legislation will give clear guidance so that the states will be able to plan their own programs soundly. Once national legislation is enacted, the opportunities for constructive action in the states will be welcomed by many progressive physicians who are experienced in dealing with state and local problems.

The national objective will be only partly reached by the passage

of the Wagner Health Bill. There will still be large problems to be solved and strong opposition to overcome. Constant vigilance will be needed against obstructive tactics and against the efforts of unfriendly interests to seize control. The legislative progress of the National Health Bill must be watched closely to see that it is not crippled by compromises.

There are, for example, those who will try to limit the benefits of the program to the indigent alone, closing the doors to low income families. Some will try to amend the bill so as to prohibit the states from experimenting with health insurance. Others will try to limit Federal aid; they would restrain the states in the services they may furnish their citizens, in the standards of competence to be required of practitioners who may furnish service or in the qualifications of the hospitals which a state is forced to use. Such efforts will ignore the fundamental right of the states to adapt their plans to their own needs or to safeguard the quality of the services to be furnished.

Some will try to pour Federal money into the construction of new private hospitals. They would thereby deprive the communities of public services which, when financed by public funds, should be wholly responsible to the citizens of the community instead of to private, self-established and self-perpetuating boards or corporations.

In these and in many other threatened efforts, the argument will be advanced that some special group can provide service so much better than government—Federal, state or local—can do it. The advocates of these special privileges will wrap themselves in the flag and will throw charges of un-Americanism at all who oppose them. Yet a little discernment will show that these clamorous "vested interests" are precisely the ones who distrust democracy and democratic government.

Despite these dangers, and the cautions we must observe, I can close this book on a note of hopefulness. All who have worked for the advancement of health services are greatly encouraged by the

progress made in the last few years. There is great public awakening. The deep and widespread interest in health measures is the best assurance that we shall have action. The presence in all parts of our country of men and women, both lay and professional, informed on health needs and eager to play their part in solving our problems, is the most solid assurance for sound action.

The time is ripe to lay aside the misunderstandings of the past and to work together harmoniously for the nation's health. I appeal to the great body of thoughtful and public spirited physicians everywhere, the real leaders of medicine, to unite with administrators, sociologists, economists, statisticians, educators and others, in establishing an effective and comprehensive health program for our democracy.

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